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Senate

The Senate met at 9:30 a.m. and was called to order by the Honorable KIRSTEN E. GILLIBRAND, a Senator from the State of New York.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Our Father in Heaven, You know all the roads by which each of us has come to serve in our government's legislative branch. You know the pathway our feet now are treading and what the future holds, for You are the architect of our destinies.

Give our Senators strength sufficient for this day. Remind them that their times are in Your hands. Infuse them with the blessed assurance that You are the love that never forgets, the light that never fails, and the life that never ends. Keep them close to You and open to each other as they do the tasks that preserve our freedoms. We pray in Your sovereign Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable KIRSTEN E. GILLIBRAND led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The bill clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 3, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable KIRSTEN E. GILLIBRAND, a Senator from the State of New York, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

Mrs. GILLIBRAND thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. REID. Madam President, following leader remarks, the Senate will resume consideration of H.R. 3590, the health reform legislation. There will be up to 10 minutes, equally divided, between the managers of the bill. The remaining time until 11:45 a.m. will be divided and controlled equally between Senator MIKULSKI and the minority leader or their designees.

At 11:45 a.m., this morning, the Senate will proceed to a series of two rollcall votes. The first vote will be in relation to the Mikulski amendment, No. 2791, as modified, to be followed by a vote on the Murkowski amendment, No. 2836.

Following those votes, the time until 2:45 p.m. will be equally divided and controlled between Senators BAUCUS and MCCAIN or their designees. At 2:45 p.m., the Senate will proceed to vote in relation to the Bennet of Colorado amendment, No. 2826, to be followed by a vote in relation to the McCain motion to commit.

All four votes today will be subject to a 60-vote affirmative threshold for adoption.

Mr. MCCONNELL. Would my friend yield for a question before making his opening remarks?

Mr. REID. I would be happy to yield.

Mr. MCCONNELL. I would say to my friend, since it is Thursday, my Members are prepared to be here Saturday and Sunday, but many would like to know whether there will be an opportunity to go to church Sunday morning.

Mr. REID. Of course. I think it very likely we wouldn't come in until noon, or somewhere around noon on Sunday.

I would indicate to my friend it appears that the next opportunity for amendment will be when we complete this. It is my understanding Senator BEN NELSON is ready, he has an amendment, and I think we have given it to your staff. This may be one where it is sponsored by people on your side also, and then we will wait to see what your next amendment will be.

Mr. MCCONNELL. I would say to my friend, obviously, I assume we are going to continue to proceed with your side offering one and my side offering one.

Mr. REID. We will show those to each other before that happens.

Mr. MCCONNELL. All right.

HEALTH CARE REFORM

Mr. REID. Madam President, we in this Chamber, a lot of times, talk as if no one is listening to what we are saying, as though we are talking to ourselves. But that is not true. The American people are listening and they are watching. That is good. But this morning I have good news and I have some bad news. The good news is, Senate Republicans finally—finally, at long last—have put a detailed plan down on paper. The bad news is, it is not as we had hoped—a plan to make health insurance more affordable, it is not one that makes health insurance companies more accountable, and it is certainly not a plan to reverse rapidly rising health care costs and draw down our deficit, such as the plan that has been submitted to the Senate and is now before the Senate by the Democrats.

Again, the plan we had hoped to receive from the Republicans would be to

make insurance more affordable, it would be one to make health insurance companies more accountable, and it would be a plan to reverse the rapidly rising health care costs and draw down our deficit. But, no, the Republican plan we have waited weeks and months to see doesn't do any of those things. In fact, it is not even about health care at all, even though it is on the health care bill, this plan they have outlined. The first and only plan Senate Republicans bothered to draft is an instructional manual on how to bring the Senate to a screeching halt. We knew that was happening anyway, but they had the audacity to put it in writing.

Madam President, I ask unanimous consent to have printed in the RECORD the letter I will be referring to.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

(See exhibit 1.)

Mr. REID. Madam President, here are some of the highlights of the Republican plan laid out in the letter I referred to:

Tips on how to force the full reading of all amendments—long amendments, short amendments.

I have no objection to transparency. That is important. Every Senator should know what he or she is voting on, but let's be truly transparent. We all know that those who would ask for such readings have no intention of sitting in this Chamber, listening to the Senate clerks. Any suggestion otherwise is simply disingenuous.

This document explains how to manipulate points of order. Yes, that is what I said, manipulate points of order—a complex but important part of the legislative process. Yet these Senators have no intention of examining the procedures of the Senate or any constitutional rules.

The document says it in plain language. The whole purpose of the document, dated the day before yesterday—December 1—a ''Dear Republican colleague'' letter, is to set forth how to slow things down, as if they needed more help to slow things down. Ninety-one times this year they have already done that. But on this bill—this bill that affects every person in America—to put in writing that they are going to do everything they can to stop this, to delay this, is beyond something that I think the American people can comprehend.

The document says in plain language that is their intention. It even condones using this tactic ''without cause.'' Do this without any reason. Just do it. The rules allow it, so go ahead and do it. It stalls things. This letter admits, in no uncertain terms, that the goal of this tactic is to delay. I didn't make up the word. It is in here. It is as clear as day.

But there is more in this plan. It also advises Senators on how to ''extend consideration of a measure,'' which motions ''may be filibustered,'' and when Senators might ''offer an unlimited number of motions.''

Well, as we see in the press, today, anyway, this has caused outrage. It is a catalogue of obstructions—a catalogue of instructions to obstruct. But what disappoints me most about this is what isn't here. Nowhere in this Republican plan is a strategy to lower premiums; not a single word about how to make sure more of our citizens can afford to stay healthy; can't even find one idea for stopping insurance companies from denying health care to the sick. You see, my Republican friends have been so busy coming up with games and gambits, with ways to distort and delay, with scare tactics and stalling tactics, that they haven't left time to come up with solutions to one of the most profound crises in the history of our country. The Senate might be interested to learn that the architect behind this blueprint is none other than the former chair of the Budget Committee, the senior Senator from New Hampshire. It is worth noting that this Senator—who, more than any other, often speaks publicly about how to properly use citizens' tax dollars—has now signed his name to a plan with the explicit goal of wasting the taxpayers' time and money.

Less than 2 weeks ago, the author of this document, along with every single one of his fellow Republicans—every one—voted against even letting the Senate debate this bill. He didn't even want to give the American people the opportunity to watch this debate take place—to discuss and defend his position. Now he expects us to believe his only motive is making sure the minority party's voice can be heard.

No one believes that because it couldn't be any further from what the Founders had in mind. They didn't write this esteemed body's rules so we could stare at the hands of the clock—which are right up here—as they rotate around each other without end. So let's not pretend the Republican strategy is anything different than what it is. After all, Republicans certainly aren't trying to hide it.

When I see these kinds of political games, I think of many cases in Nevada and around the country, but, in particular, I think of a woman from Las Vegas named Alysia. She wrote me a letter when the health care debate was getting underway. She is in her early twenties. I don't know if she is a Democrat, an Independent, or a Republican. It doesn't matter. She was born with a kidney disease, a bad kidney disease. She has suffered with it every day of her life, and these days she desperately needs surgery. But she is not going to get surgery.

Similar to so many in Nevada and across the Nation, Alysia recently lost her job. With her job lost, she lost her insurance and her health care. So Alysia went out and tried to buy a new plan to help her afford her care. No one will give her insurance. She can't find a job to get group insurance.

What did the insurance companies tell her—plural? That her kidney disorder is a preexisting condition, and because of that policy of the insurance industry, which is reprehensible, they refuse to cover her. They refuse to cover this young woman at the exact moment she needs it the most. She then tried to go get some help from Medicaid. What did she hear in response? She doesn't qualify because she isn't pregnant, she doesn't have children, and they say she doesn't have a disability.

So how can you take a woman such as Alysia out of your mind? I think she is probably following this debate. It means a lot more to her, this debate, than a legislative exercise or a political objective. She will pick up the newspaper this morning, turn on the news, or go online to read about what is happening in the Senate. Why? Because it affects her health—her pain and suffering. She probably remembers her grade school textbook teaching her that this is the world's greatest deliberative body and she is eager to find out about how those deliberations are going. She is eager to learn what we are going to do with a system that makes it impossible for her to get health care.

Who knows, she might even be watching C–SPAN as we speak. Can you imagine being Alysia and going through all that she has gone through, counting on your leaders to right the wrongs that we know exist, and this is what she finds—a Senator writing a letter on how to guide avoiding the tough decisions that will affect her life and maybe even save her life.

It is not hard to imagine. We all know you don't have to have a bad health history, such as Alysia's, to tell a similar story of your own. You may have had an accident in your early days. You may have diabetes. It doesn't matter. You don't need kidney disease for insurance companies to take away your health insurance. As it stands now, they can deny you coverage because of high cholesterol, because you have allergies or maybe you have had minor surgery or maybe because you are a woman. Maybe your mom had breast cancer. These are all reasons they use to deny coverage.

We all know that, much like our Republican colleagues, insurance companies will use any excuse in the book to just say no.

For many good people in Nevada and throughout the Nation, it is a painful, terrible reality. That is one of the many problems our good bill fixes.

The American people see transparent tricks like this—it is a shameful scheme—for what they are. The American people could not be impressed. They are not impressed. I can't decide which should disappoint the American citizens more, that the Senate Republicans are happily wasting time or that they are so eager to admit it. But here is one thing I do know, this is no way to govern, no way to legislate, this is no way to lead, and especially no way to lead our country, our constituents,

back to health. The bill before the Senate saves lives, saves money, and saves Medicare.

EXHIBIT 1

U.S. SENATE,
Washington, DC, December 1, 2009.

DEAR REPUBLICAN COLLEAGUE: As we embark on Senate debate of Majority Leader Reid's massive $2.5 trillion health care reform legislation, it is critical that Republican senators have a solid understanding of the minority's rights in the Senate.

I think that we can all agree that the Democrats' bill is the wrong choice for our nation. It will impact one-sixth of our economy, vastly grow the government, and pile tremendous debt on future generations. We are at an important crossroads both for the economy and for the health care system. Therefore, it is imperative that our voices are heard during this debate.

We, the minority party, must use the tools we have under Senate rules to insist on a full, complete and fully informed debate on the health care legislation—as well as all legislation—coming before the Senate. As laid out in the attached document, we have certain rights before measures are considered on the floor as well as certain rights during the actual consideration of measures. Every Republican senator should be familiar with the scope of these rights, which serve to protect our ability to speak on behalf of the millions of Americans who depend on us to be their voice during this historic debate.

I hope you find the attached information helpful. If you have any questions, please contact my communications office.

Sincerely,

JUDD GREGG.

FOUNDATION FOR THE MINORITY PARTY'S RIGHTS IN THE SENATE (FALL 2009)

The Senate rules are designed to give a minority of Senators the right to insist on a full, complete, and fully informed debate on all measures and issues coming before the Senate. This cornerstone of protection can only be abrogated if 60 or more Senators vote to take these rights away from the minority.

I. Rights Available to Minority Before Measures are Considered on Floor (These rights are normally waived by Unanimous Consent (UC) when time is short, but any Senator can object to the waiver.)

New Legislative Day—An adjournment of the Senate, as opposed to a recess, is required to trigger a new legislative day. A new legislative day starts with the morning hour, a 2-hour period with a number of required procedures. During part of the ''morning hour'' any Senator may make non-debatable motions to proceed to items on the Senate calendar.

One Day and Two Day Rules—The 1-day rule requires that measures must lie over one ''legislative day'' before they can be considered. All bills have to lie over one day, whether they were introduced by an individual Senator (rule XIV) or reported by a committee (rule XVII). The 2-day rule requires that IF a committee chooses to file a written report, that committee report MUST contain a CBO cost estimate, a regulatory impact statement, and detail what changes the measure makes to current law (or provide a statement why any of these cannot be done), and that report must be available at least 2 calendar days before a bill can be considered on the Senate floor. Senators may block a measure's consideration by raising a point of order if it does not meet one of these requirements.

''Hard'' Quorum Calls—Senate operates on a presumptive quorum of 51 senators and quorum calls are routinely dispensed with by unanimous consent. If UC is not granted to dispose of a routine quorum call, then the roll must continue to be called. If a quorum is not present, the only motions the leadership may make are to adjourn, to recess under a previous order, or time-consuming motions to establish a quorum that include requesting, requiring, and then arresting Senators to compel their presence in the Senate chamber.

II. Rights Available to Minority During Consideration of Measures in Senate (Many of these rights are regularly waived by Unanimous Consent.)

Motions to Proceed to Measures—with the exception of Conference Reports and Budget Resolutions, most such motions are fully debatable and 60 votes for cloture is needed to cut off extended debate.

Reading of Amendments and Conference Reports in Entirety—In most circumstances, the reading of the full text of amendments may only be dispensed with by unanimous consent. Any Senator may object to dispensing with the reading. If, as is often the case when the Senate begins consideration of a House-passed vehicle, the Majority Leader offers a full-text substitute amendment, the reading of that full-text substitute amendment can only be waived by unanimous consent. A member may only request the reading of a conference report if it is not available in printed form (100 copies available in the Senate chamber).

Senate Points of Order—A Senator may make a point of order at any point he or she believes that a Senate procedure is being violated, with or without cause. After the presiding officer rules, any Senator who disagrees with such ruling may appeal the ruling of the chair—that appeal is fully debatable. Some points of order, such as those raised on Constitutional grounds, are not ruled on by the presiding officer and the question is put to the Senate, then the point of order itself is fully debatable. The Senate may dispose of a point of order or an appeal by tabling it; however, delay is created by the two roll call votes in connection with each tabling motion (motion to table and motion to reconsider that vote).

Budget Points of Order—Many legislative proposals (bills, amendments, and conference reports) are subject to a point of order under the Budget Act or budget resolution, most of which can only be waived by 60 votes. If budget points of order lie against a measure, any Senator may raise them, and a measure cannot be passed or disposed of unless the points of order that are raised are waived. (See http://budget.senate.gov/republican/pressarchive/PointsofOrder.pdf)

AMENDMENT PROCESS

Amendment Tree Process and/or Filibuster by Amendment—until cloture is invoked, Senators may offer an unlimited number of amendments—germane or non-germane—on any subject. This is the fullest expression of a ''full, complete, and informed'' debate on a measure. It has been necessary under past Democrat majorities to use the rules governing the amendment process aggressively to ensure that minority Senators get votes on their amendment as originally written (unchanged by the Majority Democrats.)

Substitute Amendments—UC is routinely requested to treat substitute amendments as original text for purposes of further amendment, which makes it easier for the majority to offer 2nd degree amendments to gut 1st degree amendments by the minority. The minority could protect their amendments by objecting to such UC's.

Divisible Amendments—amendments are divisible upon demand by any Senator if they contain two or more parts that can stand independently of one another. This can be used to fight efforts to block the minority from offering all of their amendments, because a single amendment could be drafted, offered at a point when such an amendment is in order, and then divided into multiple component parts for separate consideration and votes. Demanding division of amendments can also be used to extend consideration of a measure. Amendments to strike and insert text cannot be divided.

Motions to Recommit Bills to Committee With or Without Instructions—A Senator may make a motion to recommit a bill to the committee with or without instructions to the Committee to report it back to the Senate with certain changes or additions. Such instructions are amendable.

AFTER PASSAGE GOING TO CONFERENCE, MOTIONS TO INSTRUCT CONFEREES, MATTERS OUT OF SCOPE OF CONFERENCE

Going to Conference—The Senate must pass 3 separate motions to go to conference: (1) a motion to insist on its amendments or disagree with the House amendments; (2) a motion to request/agree to a conference; and (3) a motion to authorize the Chair to appoint conferees. The Senate routinely does this by UC, but if a Senator objects the Senate must debate each step and all 3 motions may be filibustered (requiring a cloture vote to end debate).

Motion to Instruct Conferees—Once the Senate adopts the first two motions, Senators may offer an unlimited number of motions to instruct the Senate's conferees. The motions to instruct are amendable—and divisible upon demand—by Senators if they contain more than one separate and distinct instruction.

Conference Reports, Out of Scope Motions—In addition to demanding a copy of the conference report to be on every Senator's desk and raising Budget points of order against it, Senators may also raise a point of order that it contains matter not related to the matters originally submitted to the conference by either chamber. If the Chair sustains the point or order, the provision(s) is stricken from the conference agreement, and the House would then have to approve the measure absent the stricken provision (even if the House had already acted on the conference report). The scope point of order can be waived by 60 Senators.

Availability of Conference Report Language. The conference report must be publicly available on a website 48 hours in advance prior to the vote on passage.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

HEALTH CARE REFORM

Mr. MCCONNELL. Madam President, this measure was in the majority leader's office for 6 weeks. It has only been on the floor of the Senate for 3 days. I think it is clearly not the case that the Republicans want to delay a process that we have only now gotten an opportunity to participate in, since this has been a strictly partisan venture from the beginning. But we will have an opportunity over a number of weeks to offer amendments. We will have four votes today and hopefully we can proceed at a more rapid pace than we got off to in the first couple of days. Of

course the reason we didn't have votes last night was because there were objections on that side of the aisle. But hopefully we are now into a process where we can go forward without the kind of delay that we had generated by both sides over the last couple of days.

Yesterday some of our friends on the other side were at great pains to explain one of the core pieces of their health care plan. I am referring of course to the massive cuts in Medicare they plan to make as a way of expanding government's reach even further into the lives and, more specifically, into the medical care of every American.

I have no doubt that our friends were reluctant to call for these cuts. But in the middle of a recession, and at a time when more than 1 in 10 working Americans is looking for work, it isn't easy to find $1/2 a trillion lying around. They had to find the money somewhere. And so they set their sights on Medicare.

Republicans have been entirely consistent in this debate: Medicare is already in trouble. The program needs to be fixed, not raided to create another new government program. We have fought these senseless cuts from the outset. And we will continue to fight them.

Democrats, meanwhile, have taken a novel approach. They have apparently decided there is no way to defend these Medicare cuts, so they will just deny they are doing it. It hardly passes the smell test.

Here are the facts. According to this bill: Medicare Advantage is cut by $120 billion; hospitals that treat Medicare patients are cut by $135 billion; home health care is cut by more than $42 billion; nursing homes are cut by nearly $15 billion; hospice care is cut by $7.6 billion.

These are the cuts that our friends on the other side claim not to be cuts. This is the plan that our friends on the other side have said will ''save Medicare''—a talking point so plainly contradicted by the facts, it is almost impossible to repeat it with a straight face.

One Democrat took this strategy to a new level yesterday when he declared on the floor that it wasn't even accurate to describe cuts to Medicare Advantage as cuts because Medicare Advantage, he said, is not a Medicare Program.

Well, that is apparently news to the Department of Health and Human Services, which states on its Web site, in words as plain as the alphabet that ''Medicare Advantage plans . . . are part of the Medicare program.'' And it is news to the millions of American seniors who depend on this popular program for their care.

At the moment, Medicare Advantage has nearly 11 million enrollees looking at it another way, or nearly one-fourth of all Medicare beneficiaries are on Medicare Advantage.

In recent years, this program has proven to be particularly popular with seniors in rural areas who would otherwise have limited access to care. Seniors have shown they want this plan. And I daresay that if you had asked seniors earlier this year what they expected health care reform would look like, it wouldn't have involved massive cuts to a program that they have shown they like and want.

Medicare Advantage has also been proven to help in a particular way low-income and minority seniors. That is one of the reasons minorities are more likely to enroll in it. So this program has given a boost to historically disadvantaged populations and helped give them a greater measure of dignity toward the end of their lives.

These cuts are bad enough. But despite what our friends have said, the Democrat plan for Medicare Advantage doesn't stop here because their bill also gives the Medicare Commission explicit new authority to cut even more from this popular program in the years ahead.

The President has repeatedly said that people who like the plans they have will be able to keep them under his plan. He has said people currently signed up for Medicare Advantage will have the same level of benefits under his plan.

Well, common sense tells us that you can't cut $120 billion from a benefits program without affecting benefits, and the independent Congressional Budget Office confirms what common sense tells us, and they actually quantify it.

CBO says the bill we are debating will cut extra benefits that seniors receive through Medicare Advantage by more than half. The fact is, cuts to Medicare Advantage are cuts to Medicare. And if it is true of Medicare Advantage, it is true of the other Medicare cuts in this bill. Democrats can deny these cuts all they want. Seniors aren't buying it.

Later this afternoon we are going to have a Bennet amendment, Bennet of Colorado, as a side-by-side to Senator MCCAIN's motion, which would send back to committee the Medicare cuts in this bill and ask the committee to report it back without them. I want to comment briefly on the Bennet amendment and we are going to have more to say on that during the course of today's debate.

This amendment is a shell game, a shell game designed to hide the $½ trillion in cuts I have been talking about. The Bennet of Colorado amendment is a shell game designed to hide the $½ trillion in cuts I have described. If the Bennet amendment passes, the bill will still cut $½ trillion from Medicare.

Let me say that again. If the Bennet of Colorado amendment passes, the bill will still cut $½ trillion from Medicare. It does not protect Medicare. There is only one way to protect Medicare and that is to support the McCain motion.

I yield the floor.

Mr. GREGG. Will the Senator yield for a question?

Mr. MCCONNELL. I will be happy to yield to the Senator from New Hampshire.

Mr. GREGG. The Senator is absolutely right to point out the Bennet amendment is a shell game, charade, and a farce; that there will still be $½ trillion in the first 10 years but actually $2.5 trillion over the period 2010 to 2029 to be cut out of Medicare.

Earlier the majority leader came to the floor and talked about a memo that I sent around, which is a fairly innocuous memo to our fellow Members, which outlined the rights to fellow Members relative to floor activity, and I sent in my position as Budget ranking member, because most of these issues are tied to the budget, and the covering letter said we as a minority must use the tools we have under the Senate rules to insist on a full, complete, and fully informed debate on health care legislation as well as all legislation that comes before the Senate.

I ask the Republican leader, is it not reasonable that we should have a full, complete, and fair debate on this health care bill?

Mr. MCCONNELL. I say to my friend from New Hampshire, we know this bill was produced by Democrats in committee. Then it went to the majority leader's conference room and stayed there for 6 weeks. There were no Republicans in those meetings, not a one. So after being in the majority leader's conference room for 6 weeks, it has been on the floor of the Senate for 3 days. This will be the fourth day.

To suggest that Republicans don't want to offer many amendments to this massive 2,000-page bill that seeks to restructure one-sixth of our economy is nonsense. The American people will not stand for not having a free and open amendment process during the course of this debate. This is a debate, I say to my friend from New Hampshire, the American people deserve to have for a considerable period of time. For goodness' sake, we spent 4 weeks on a farm bill in the last Congress. F

Mr. GREGG. If the Republican leader will yield further, it is ironic, is it not, that the majority leader would come to the floor and complain about an innocuous statement that outlines the rules which Members of the Senate have, a statement which I suspect he actually would pass out to his members for information were they in the minority—maybe even in the majority, because they would like to know how the rules work in the Senate—after the majority leader had completely subverted the rules of the Senate by not taking this 2074-page bill through committee so it could be amended, in the open, so it could be amended but, rather, writing it in the back room, some closet around here, with three or four Members of the Senate present? Isn't there an ironic inconsistency to his outrage on the fact that we suggested people should know the rules here while he has basically tried to go around the rules?

Mr. MCCONNELL. I say to my friend from New Hampshire, nobody is going to buy outrage over a mere 40 Members out of 100 Members of the Senate having an opportunity, for the first time, to offer amendments. The majority, by the way, has the right to do this, and I don't complain about it. They are going to offer an amendment for every amendment we offer, so not only did they have the bill in their conference room in secret for 6 weeks, out here on the floor they are going to get 50 percent of the amendments we vote on. I don't think they will be able, with a straight face, to convince the American people that somehow the 40 of us who are asking for an opportunity to amend a bill that all the surveys indicate the American people don't want us to pass is somehow unfair.

Mr. GREGG. I will ask one more question because I find the irony in the situation so unique. A memo which outlines what the rights are of all Members—but Members of the minority specifically because the rules are meant to protect the minority from the majority; that is the tradition of our Government, of course, which seems to be an affront to the majority at this point—that a memo of that nature, which essentially says the minority has certain rights in order for the institution to function correctly—I am wondering, why did we create these rules in the first place? Wasn't it so we could continue the thought of Adams, of Madison, who suggested that the Senate should be the place where, when legislation comes forward which has been rushed through the House, the Senate should be the place where that legislation receives a deliberative view, where it is explored as to its unintended consequences and as to its consequences generally, and where the body has the opportunity to amend it effectively so it can be improved? Isn't that the purpose of the Senate? And isn't that what the rules of the Senate are designed to do, to accomplish the goals of our Founding Fathers to have a Senate where the legislation is adequately aired and considered versus being rushed through in a precipitous way?

Mr. MCCONNELL. It was George Washington who presided over the Constitutional Convention who was asked: General, what do you think the Senate is going to be like?

He said: I think it is going to be like the saucer under the tea cup and the tea is going to slosh out of the cup down into the saucer and cool off. That is precisely the point the Senator raises, which is the Senate is the place viewed to be a body that ought to and correctly takes its time. The House of Representatives passed this massive restructuring of one-sixth of our economy in 1 day with three amendments—1 day. That is not the way the Senate operates. I can remember when our friends on the other side were in the minority. Specifically, I can remember the now-assistant majority leader saying the Senate is not the House—praised the procedures in the Senate. If ever there were a measure, if ever in the history of America there were a measure that the Americans expect us to take our time on and to get it right, it is this one, this massive 2,000-page effort to restructure one-sixth of our economy and have the government take over all of American health where we see, in all of the public opinion polls, people are saying please don't pass this—they want to try to rush it.

They want to try to rush it, try to get it through here in a heck of a hurry, back it up against Christmas. I have said to the majority leader, we are happy to be here. We are going to be here Saturday and Sunday. I did ask for an opportunity for Members to go to church Sunday morning, if they want to, and the majority leader indicated that would be permissible. But after that, we will be here and ready to vote.

Mr. GREGG. I thank the Republican leader for his response. I suspect, were the majority leader in the minority, he would be insisting on exactly what the Republican leader is insisting on—a fair and open debate which allows the minority to make its case as to the good points in this bill and as to the bad points. The way you make that case is by following the rules of the Senate; is that not correct?

Mr. MCCONNELL. The American people expect and deserve no less than exactly what we have been discussing.

I yield the floor.

RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The bill clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time home buyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

Mikulski amendment No. 2791 (to amendment No. 2786), to clarify provisions relating to first-dollar coverage for preventive services for women.

McCain motion to commit the bill to the Committee on Finance, with instructions.

The ACTING PRESIDENT pro tempore. Under the previous order, there will be 10 minutes equally divided for the bill managers to speak.

The Senator from Montana.

Mr. BAUCUS. Madam President, I yield myself 2½ minutes from the time under the control of the managers.

For the benefit of all Senators I want to take a moment to lay out today's program.

The time between now and 11:45 is for debate on the amendment by the Senator from Maryland, Ms. MIKULSKI, the chairwoman of the Subcommittee on Retirement and Aging of the Health, Education, Labor and Pensions Committee.

And at the same time, we will debate the side-by-side amendment by the Senator from Alaska, Ms. MURKOWSKI.

At 11:45, the Senate will conduct two back-to-back rollcall votes on the two amendments, first on the amendment by the Senator from Maryland, and second on the amendment by the Senator from Alaska.

Thereafter, we will conduct approximately 2 hours of debate on the McCain motion to commit on Medicare and the side-by-side amendment by the Senator from Colorado, Mr. BENNET.

At 2:45, the Senate will conduct two back-to-back votes on the amendment by the Senator from Colorado, followed by a vote on the motion to commit by the Senator from Arizona.

Thereafter, we expect to turn to another Democratic first-degree amendment and another Republican first-degree amendment.

This is the fourth day on this bill, and we are only late this morning coming to our first vote. Even for the U.S. Senate, this is a slow pace.

I note that some have made plans for delaying this bill in even more extreme fashion. As the majority leader noted, on Tuesday, one Senator circulated a list of delaying tactics available under the Senate rules.

I presume all Senators know the Senate's rules already. So to send the letter leaves the impression that that Senator would like to urge Senators to use some of the delaying tactics stated in the memo.

But I urge a more cooperative course. Out of courtesy to other Senators who desire to offer amendments. I urge my colleagues to allow us to reach unanimous consent agreements to order the voting of future amendments in a more timely fashion. That is simply the only way that we can ensure that more colleagues will have the time and opportunity to offer and debate their amendments.

I thank all Senators.

The ACTING PRESIDENT pro tempore. The Senator has consumed his time.

Mr. BAUCUS. I ask unanimous consent that the order of December 2 be modified to delete all after the word ''table.''

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. BAUCUS. I ask unanimous consent that the debate time from 2 to 2:45 this afternoon be divided as follows in the order listed: the first 17½ minutes under the control of Senator MCCAIN or his designee; the next 17 minutes under the control of Senator BAUCUS or his designee; and the final 10 minutes, 5 minutes each for Senator MCCAIN and Senator BENNET of Colorado.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

The Senator from Iowa.

Mr. HARKIN. Madam President, I heard the distinguished minority leader earlier in his comments say that one of the reasons they are slowing this bill down and having all this debate is it has been a strictly partisan venture thus far. I beg to differ with the minority leader.

I see our distinguished ranking member of the HELP Committee here on the floor. In the HELP Committee, for the enlightenment of Senators, we had 13 days of markup, 54 hours, 788 amendments were filed, 287 amendments were considered and debated and voted on or accepted, and 161 Republican amendments were adopted. No one was denied the opportunity to offer any amendment, to discuss them, debate them, and get a vote or have it accepted, whatever the case might be. To me, this is truly a bipartisan way of proceeding.

The minority leader's argument basically goes to the fact that the people of this country overwhelmingly elected Democrats to guide and make changes for the future. One of the biggest changes is in our health care system. One of the responsibilities of being a majority party is to propose. That is what we have done. We are proposing changes in the health care system. The function of the minority is to offer amendments, constructive amendments, offer different ideas, and if their ideas are better or if they receive majority approval, then the bill is thus changed. That happened in the HELP Committee. As I said, 161 Republican amendments were adopted. To me, that is bipartisan. That is what we have been doing. What is kind of not acceptable is this idea that things are just going to slow down for the purposes of delaying and eventually making sure we don't have a bill.

Let me say that after all that lengthy debate we had in the HELP Committee, we passed a bill. The same will happen here on the Senate floor. I don't care how many times the minority wants to drag it out and slow it down to try to kill this bill, this bill will pass the Senate, we will go to conference, and we will have it on the President's desk early next year.

The ACTING PRESIDENT pro tempore. The Senator from Wyoming.

Mr. ENZI. I appreciate the comments, some of which need correction, from yesterday and those that have just been made.

On a partisan bill, I sat through all of those days in the HELP Committee. That bill was rushed and put together. Senator Kennedy was not able to be involved in that part of it. His staff did it. They did it in a hurry. We turned in 159 amendments that were accepted. Most of those were for typos and minor corrections. There were a few that actually had some substance to them. That bill was passed on July 15 out of committee without a single Republican vote. It wasn't published. We didn't see the final version until September 17. The ones that were really something that could have made a difference were taken out without the permission of any Republican Senator. That is not bipartisan.

We talked about how many hours we spent together. If you don't accept things from the minority party, it is not bipartisan. It is still partisan. Just spending hours doesn't make any difference.

To move on to a different topic, yesterday we were talking about costs. I hope the people take a look at a Wall Street Journal article from yesterday that says:

> A bill that raises prices but lowers costs, and other miracles.

We heard all day yesterday that this bill is going to save people a lot of money. This article reads:

> We have now reached the stage of the health-care debate when all that matters is getting a bill passed, so all news is good news, more subsidies mean lower deficits, and more expensive insurance is really cheaper insurance. The nonpolitical mind reels.
>
> Consider how Washington received the Congressional Budget Office's study Monday of how Harry Reid's Senate bill will affect insurance costs, which by any rational measure ought to have been a disaster for the bill.
>
> CBO found that premiums in the individual market will rise by 10% to 13% more than if Congress did nothing. Family policies under the status quo are projected to cost $13,100 on average, but under ObamaCare will jump to $15,200. Fabulous news! ''No Big Cost Rise in U.S. Premiums Is Seen in Study,'' said the New York Times, while the Washington Post declared, ''Senate Health Bill Gets a Boost.'' The White House crowed that the CBO report was ''more good news about what reform will mean for families struggling to keep up with skyrocketing premiums under the broken status quo.'' Finance Chairman Max Baucus chimed in from the Senate floor that ''Health-care reform is fundamentally about lower health-care costs. Lowering costs is what health-care reform is designed to do, lowering costs; and it will achieve this objective.''
>
> Except it won't. CBO says it expects employer-sponsored insurance costs to remain roughly in line with the status quo, yet even this is a failure by Mr. Baucus's and the White House's own standards.
>
> Meanwhile, fixing the individual market—which is expensive and unstable largely because it does not enjoy the favorable tax treatment given to job-based coverage—was supposed to be the whole purpose of ''reform.'' Instead, CBO is confirming that new coverage mandates will drive premiums higher. But Democrats are declaring victory, claiming that these higher insurance prices don't count because they will be offset by new government subsidies.
>
> About 57% of the people who buy insurance through the bill's new ''exchanges'' that will supplant today's individual market will qualify for subsidies that cover about two-thirds of the total premium. So the bill will increase costs but it will then disguise those costs by transferring them to taxpayers from individuals. Higher costs can be conjured away because they're suddenly on the government balance sheet. The Reid bill's $371.9 billion in new health taxes are also apparently not a new cost because they can be passed along to consumers, or perhaps will be hidden in lost wages. This is the paleoliberal school of brute-force wealth redistribution, and a very long way from the repeated White House claims that reform is all about ''bending the cost curve.'' The only thing being bent here is the budget truth.
>
> Moreover, CBO is almost certainly underestimating the cost increases. Based on its county-by-county actuarial data, the insurer WellPoint has calculated that Mr. Baucus's bill would cause some premiums to triple in the individual market. The Blue Cross Blue Shield Association came to similar conclusions. One reason is community rating, which forces insurers to charge nearly uniform rates regardless of customer health status or habits. CBO doesn't think this will have much of an effect, but costs inevitably rise when insurers aren't allowed to price based on risk. This is why today some 35 states impose no limits on premium variation and six allow wide differences among consumers.
>
> The White House decided to shoot messengers like WellPoint to avoid rebutting their message. But Amanda Kowalski of MIT, William Congdon of the Brookings Institution and Mark Showalter of Brigham Young have found similar results. In a 2008 paper in the peer-reviewed Forum for Health Economics and Policy, these economists found that state community rating laws raise premiums in the individual market by 20.9% to 33.1% for families and 10.2% to 17.1% for singles. In New Jersey, which also requires insurers to accept all comers (so-called guaranteed issue), premiums increased by as much as 227%.
>
> The political tragedy is that there are plenty of reform alternatives that really would reduce the cost of insurance. According to CBO, the relatively modest House GOP bill would actually reduce premiums by 5% to 8% in the individual market in 2016, and by 7% to 10% for small businesses. The GOP reforms would also do so without imposing huge new taxes. But Democrats don't care because their bill isn't really about ''lowering costs.'' It's about putting Washington in charge of health insurance, at any cost.

The ACTING PRESIDENT pro tempore. The time of the Senator has expired.

Under the previous order, the time until 11:45 a.m. shall be equally divided between the Senator from Maryland, Ms. MIKULSKI, and the Republican leader or his designee.

Mr. HARKIN. Madam President, parliamentary inquiry: There is time between now and the hour of 11:45 a.m. equally divided between the Republican side and the Democratic side; is that correct?

The ACTING PRESIDENT pro tempore. That is correct.

Mr. HARKIN. Madam President, I assume, then, the normal thing will be to go back and forth from one side to the other, the Republican side and the Democratic side?

The ACTING PRESIDENT pro tempore. That will not be an order unless it is propounded.

Mr. BAUCUS. Madam President, I think it is perfectly understood.

Mr. ENZI. That is our understanding as well.

Mr. HARKIN. Madam President, I ask unanimous consent to be recognized for 7 minutes.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. BAUCUS. Madam President, will the Senator yield for a quick inquiry to my friend from Wyoming?

Mr. HARKIN. Yes.

Mr. BAUCUS. Madam President, I might inquire of my colleague from Wyoming if that item the Senator was quoting from about costs in the Wall Street Journal was a news article or an editorial.

Mr. ENZI. That was an editorial by the Wall Street Journal, the staff of the Wall Street Journal, confirmed by MIT, Brigham Young, and others.

Mr. HARKIN. Madam President, I ask if the Chair will remind me when the 7 minutes is up.

The ACTING PRESIDENT pro tempore. The Chair will do so.

Mr. HARKIN. Madam President, I have to respond to my friend from Wyoming about doing this in a hurry. He mentioned that we did the bill in a hurry in our committee. Actually, it was last November, shortly after the election, when I received a call from Senator Kennedy talking about doing a health reform bill, asking if I would take charge of a section dealing with public health and prevention and wellness. I think then he asked Senator MURRAY to take over workforce development, Senator BINGAMAN did coverage, and Senator MIKULSKI did quality improvements. So that was in November.

I cannot speak for the others who did the other sections. All I can say is, on our side, in what I did, we had five hearings. We had five hearings on public health and prevention and wellness and what ought to go into a bill. I think those hearings commenced in December and went through about February. Then we worked until June, and we did not start our markup until June. So we had almost 6 months of hearings and putting things together in the bill before we started a markup. I rather doubt that can be said to be rushing anything.

But I just want to focus on the vote that is coming up on the amendment offered by the Senator from Maryland, Ms. MIKULSKI, which will strengthen provisions in the bill concerning preventive health benefits for women.

As an initial matter, I am proud of the significant investments the bill makes overall in wellness and prevention. It has not been talked about very much. If you read the public press out there, the popular press, and watch TV, about the only thing you think is in the bill is a public option and abortion and that is what this bill is about. Well, those may be the hot points and the flashpoints—it makes for good press—but I submit that one of the most important parts, if not the most important part, of this bill is what it does for prevention and wellness, trying to move our costs upstream, keeping people healthy in the first place.

I have said many times, what good does it do us if we are just going to pour more money into paying bills for a broken, dysfunctional, sick care system—not a health care system, a sick care system? That is what we have in America today. This bill begins the transformation of moving us from a sick care system to a true health care system.

The Senator from Maryland has a very important amendment to make clear—to make clear—that what is included in the bill is to strengthen the preventive services that basically inure to the women of this country. The Mikulski amendment reiterates the recommendations of our bill, and it also points out that the recommendations of the U.S. Preventive Services Task Force is a floor, not a ceiling—it is a minimum. In other words, health plans are required at a minimum to provide first-dollar coverage for preventive services recommended by the Preventive Services Task Force, but that is just the minimum. The Secretary of Health and Human Services has full discretion to identify additional preventive services that will be part of the essential package offered by health insurance on the exchange.

Again, there has been some talk here about this task force, the Preventive Services Task Force, that somehow this is a bunch of bureaucrats, it is a government-run task force, it has a political agenda. I have heard all these things said on the floor in the last day or so. Well, in fact, the Preventive Services Task Force is an independent body that evaluates the benefits of clinical preventive services. It makes recommendations—again, no decisions, merely recommendations—about which services are most effective.

Who is on this task force? Experts and leaders in primary care who are renowned internists, pediatricians, family physicians, gynecologists, and obstetricians. And these professionals are not located in Washington, DC; they are based all over the country. Some may be in one State or another State. They are all over the country, and they are experts in these different areas, recognized by their peers. They do not sit in an office at Health and Human Services. They bring years of medical training and experience to the jobs they do.

Does that mean they never make a mistake? No. No one is perfect. No Senator is perfect. Neither is every doctor perfect. And neither is any task force always going to make what we might consider to be the perfect answer. But our bill does not grant them the authority to tell insurance companies what not to cover. That is clear. But to hear the debate on the floor, you would think it is just the opposite, that the Preventive Services Task Force can tell insurance companies what they cannot cover. That is not true. Our bill says that those recommendations that are A and B—categorized by the Preventive Services Task Force, by these expert doctors around the country—these are the ones they say really are key preventive services, have the most benefit. We say in our bill that those services must be covered without copays, without deductibles. That means that is the floor. That is the floor.

Again, I might also add that preventive services that are rated by the Advisory Committee on Immunization Practices and comprehensive guidelines supported by the Health Resources and Services Administration are also part of the recommendations to establish that floor.

So, again, I would say it is a pretty big floor when you put all those together. Again, it does not establish a ceiling and it does not say what cannot be done. It just says you have to do these basics. That is the floor.

I do understand the concerns of some that the task force has not spent enough time studying preventative services that are unique to women. Senator MIKULSKI goes back a long way on this issue. I can remember some years ago Senator MIKULSKI pointing out to me, in my capacity as the then-chairman of the Appropriations subcommittee that funds NIH——

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

Mr. HARKIN. Madam President, I ask unanimous consent for 3 more minutes.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. HARKIN. Senator MIKULSKI said: If you look at the research being done at NIH, it is almost all done on men and not on women. I remember that some years ago, and all of a sudden a lightbulb went off in my head. I said: You are right. So we had to start changing the focus of a lot of the research done to focus on the unique situations faced by women.

Well, this was also a concern that was raised in our HELP Committee by Senator MIKULSKI, and we included language to require all health plans to cover comprehensive women's preventive care and screenings based on guidelines promulgated by the Health Resources and Services Administration—again, without any copays or deductibles. That was in our health bill but unfortunately was not included in the merged bill. But Senator MIKULSKI's amendment, which we are about to vote on, brings us back to the position we had in the HELP Committee bill. I think that was largely supported, if I am not mistaken, on both sides, at least in our HELP Committee. At least no one offered any amendment to strike it when we were debating it in committee. So I assume it was supported generally by both Republicans and Democrats.

By voting for the Mikulski amendment, we can make doubly sure that the floor we are establishing in the bill for preventive services that are unique to women also has no copays and no deductibles. Again, that is why this amendment is so important.

I know our friend Senator MURKOWSKI has a different way of approach. I commend her for her involvement and her interest in this issue. She has been a great member of our committee, and I have done a lot of great work with Senator MURKOWSKI. But I think her amendment misses the mark in this way: It asks insurers to use guidelines from provider groups when making coverage decisions. Well, that does not guarantee women will get any of the preventive services they need.

Here is a statement from the American Heart Association and the American Stroke Association. It says:

. . . we are concerned that Senator Murkowski's preventive health services amendment would take a step backwards by substituting the judgment of the independent U.S. Preventive Services Task Force with the judgment of private health insurance companies.

Madam President, I ask unanimous consent that this letter from the American Heart Association and the American Stroke Association be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

STATEMENT BY AMERICAN HEART ASSOCIATION CEO NANCY BROWN ON MURKOWSKI AMENDMENT ON PREVENTIVE HEALTH SERVICES

(Dec. 2, 2009)

The American Heart Association strongly supports requiring health plans and Medicare to provide first-dollar coverage for clinical preventive services that are evidence-based and necessary for the prevention or early detection of an illness or disability. We appreciate that Senator Murkowski's amendment recognizes the value of the guidelines and recommendations made by professional medical organizations (as well as by voluntary health organizations like the American Heart Association). But even these guidelines must be held to the standard of being evidenced based. In addition, we are concerned that Senator Murkowski's preventive health services amendment would take a step backwards by substituting the judgment of the independent U.S. Preventive Services Task Force with the judgment of private health insurance companies. Although we have previously recommended to Congress that the USPSTF membership be expanded to include specialists to broaden the expertise of the Task Force, we believe an expanded USPSTF would be the best entity to objectively and rigorously make recommendations for covering clinical preventive services and do not support eliminating it from this role.

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

Mr. HARKIN. Madam President, I will have more to say about the Murkowski amendment later. But, again, the point is, the Mikulski amendment is right on point. It should be adopted.

The ACTING PRESIDENT pro tempore. Who yields time?

Mr. ENZI. Madam President, I yield 10 minutes to the Senator from Florida.

The ACTING PRESIDENT pro tempore. The Senator from Florida.

Mr. LEMIEUX. Madam President, I come to the floor today to draw back the curtain a little, I hope, and to widen the lens to talk about the issue of the bill before us, not just on this particular amendment but on what it is going to mean for my constituents in Florida and for the people of this country.

I had the opportunity last week to be back home in Florida, in south Florida, in Palm Beach County and Broward County and Miami-Dade County, where I talked to doctors, hospital administrators, folks who run Medicare Advantage plans, as well as everyday Floridians, specifically senior citizens. The responses I heard were nearly unanimous, and that was grave concern about the bill that is being debated on this floor and a general confusion as to why the Congress is pursuing the path that it is. The people of Florida do not understand why we are going to cut Medicare to create a new program. The people of Florida do not understand why we are going to raise taxes to create a new program. The people whom I have spoken to in Florida do not understand why we would undertake a new $2.5 trillion health care proposal if it was not going to reduce the cost of health insurance for the 170 million to 180 million Americans who have health insurance today.

Why are we embarking upon this measure if it is not going to affect most everyday Floridians and everyday Americans who are struggling under the high cost of health insurance? Health insurance premiums have increased 130 percent in the past 10 years.

When the President put this proposal forward and when he campaigned on it, he said his major goal was to reduce the cost of health insurance. When he addressed the Nation in a joint session of Congress on September 9, he said his plan would reduce the cost of health insurance. But we find out that for at least 32 million Americans, it will raise the cost of health insurance 10 to 13 percent. So at least half of the goal, if not most of the goal, of his plan for most Americans in this country will not be accomplished. Yet we are going to cut nearly $½ trillion out of Medicare, we are going to raise taxes by $½ trillion, and we are going to spend $2.5 trillion on this program, which was admitted to by Senator BAUCUS yesterday on the floor, which cannot be, under my understanding, in any way budget neutral.

But I want to speak specifically about the cuts to Medicare. It cuts $192 billion, according to the Congressional Budget Office, ''to Medicare's payment rates for most services.'' I think we have to be clear here that if you cut providers, you are going to cut services. The very reason we talked about increasing doctor payments in that $¼ trillion program was so that patients would not receive fewer services, so there would be ample doctors providing services for Medicare. It is beyond logic to argue that cutting providers will not cut services. What will happen when we cut providers, doctors, nursing homes, home health agencies, hospitals? Fewer and fewer of them will provide benefits, and fewer and fewer of them will take Medicare.

The Chief Actuary of CMS believes the cuts in the bill we have before us could cause providers to end their participation in Medicare:

. . . providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and might end their participation in the program.

Every American understands this. If we pay less money to health care providers, they are going to offer less benefits or more and more they are not going to participate in Medicare.

The Medicare Payment Advisory Commission found in June of last year that 29 percent of Medicare beneficiaries who were looking for a primary care doctor had a problem finding one to treat them. This is of grave concern to the 3 million Floridians who are on Medicare. If a doctor will not see them, what kind of health care plan is this? These seniors, our ''greatest generation,'' have paid into this program their whole life. It is illusory if they can't find a doctor who will treat them.

One of my constituents, Earl Bean, from Sanford, FL, recently told CNN that he called about 15 doctors when he was trying to find health care, and he was told they were not taking new Medicare patients. So when we cut $½ trillion out of Medicare, is that going to improve health care for seniors or is it going to continue to decline health care for seniors? You can't get blood from a stone. It is going to make the situation worse. For anyone to come to this floor and say that it would not is incredible.

We have in Florida the second highest Medicare population. When we cut $135 billion from hospitals and $21 billion from the disproportionate share fund, which is basically money that goes to these hospitals to provide health care for seniors and the indigent, how are they going to be able to provide that health care? I spoke to the administrator of the North Broward Hospital District and told him about this cut to the DSH funds, and he told me it would be devastating to their provision of health care.

Then we are going to take a very popular program called Medicare Advantage—more than 900,000 Floridians in my State—and we are going to cut it as well. I recently visited the Leon Medical Center and their new facility in Miami Dade County where they provide state-of-the-art, first-class health care for seniors; not only normal health care but eyeglasses, hearing aids, dental care, and the constituents who go there love it. They are getting the kind of health care that you would hope your senior citizens in your family would get.

The principal of the company, Ben Leon, told me they have saved $70 billion in the way they have run their system. He told me if we continue on this path with these cuts to Medicare Advantage, he will not be able to provide

these good services going forward. There are some fixes to grandfather folks in, but all in all people will be cut, and all in all the program will not be as good, and it will decline the health care of seniors in Florida and across this country.

We will cut $15 billion from nursing home care and $40 billion from home health agencies. I spoke to a provider of a home health agency practice in Florida. He said these cuts will put half of the home health care agency folks out of business. At a time when we have 11.2 percent unemployment in Florida, this health care bill is going to cost people their jobs, and it is going to decline the quality of health care.

I am also concerned about this Medicare advisory board. This independent board of nonelected folks is going to have the power to cut Medicare by $23 billion over the next 10 years, and it will be up to this body to reinstate those cuts. These people are not elected, my constituents in Florida don't know who they are, but they are going to be responsible for the decline of their Medicare and their health care.

The ''greatest generation,'' who fought to protect this country, is looking at this health care bill and wondering why. Folks with health insurance in this country—more than 170 million who are not going to see their health care costs go down but up—are wondering why. Americans who are seeing higher taxes and penalties for not buying these health insurance programs under this bill are wondering why.

If we are here to reform health care—and we should be—if we are here to try to make sure the 45 million people in this country and the nearly 4 million Floridians get health insurance—and we should be—then why don't we take a step-by-step approach?

I am new to this body. My first day here was September 10, so I have not even been here 3 months. But I can tell my colleagues, the American people, if they knew what I know now and could see what I see, would be baffled by this process. There is not a give-and-take on this issue. We didn't all sit down together in a conference room and work this out to have a bipartisan bill. The Democratic leader worked on it with his colleagues but not with us.

So now we have a program that cuts Medicare, that raises taxes, that doesn't decrease the cost of health care for the majority of Americans and will cost us $2.5 trillion and can't be budget-neutral, at a time when we have a $12 trillion debt, a debt that requires each of us—each family—to put $100,000 on our shoulders to be responsible for that debt, a debt where the third largest payment in our budget is for interest payments, and over the next 10 years those interest payments will go up by $500 billion, enough to pay for many of the budgets of the Federal Government——

The ACTING PRESIDENT pro tempore. The Senator has used his 10 minutes.

Mr. LEMIEUX. Including the wars in Afghanistan and Iraq.

I thank the Chair, and I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Maryland is recognized.

Mr. HARKIN. How much time would the Senator like to consume?

The ACTING PRESIDENT pro tempore. The Senator from Maryland controls the time, and the Senator from Maryland has 33 minutes.

Ms. MIKULSKI. Madam President, I yield myself a firm 10 minutes.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Ms. MIKULSKI. Madam President, health care is a woman's issue. Health care reform is a must-do woman's issue, and health insurance reform is a must-change issue.

So many of the women and men of the Senate are here today to fight for change and to make sure we have universal access to health care. When we have universal access, it makes a difference in our lives, which means we have to have universal access to preventive and screening services.

My amendment—and, by the way, it is a bipartisan amendment—makes universal access to preventive and screening services for women available.

There is much discussion about whether women should get a particular service at a particular age. We don't mandate that women get a service; we leave that up to a decision made with the woman and her doctor. But, first of all, they need to be able to have a doctor. So we are for universal access, and this is why the underlying bill is so important.

Then, when you have that, there should also be universal access to preventive and screening services, particularly to the top killers of women, those things that are unique to women. We think about cancer: breast cancer, ovarian cancer, and cervical cancer. Also, women are dying at an increased rate of lung cancer. Then there are these other silent killers that have had a lethal effect on women, and that is cardio and vascular disease. So we want to guarantee universal access to medically appropriate or medically necessary screening and preventive services.

Many women don't get these services because, first of all, they don't have health insurance; and, No. 2, when they do have it, it means these services are either not available unless they are mandated by States or the copayments are so high that they avoid getting them in the first place.

The second important point about my amendment is it eliminates deductibles and copayments. So we eliminate two big hurdles: having insurance in the first place, which is the underlying bill, as well as copayments and deductibles. I know of no one in this room who would not want to be on our side on this issue.

I wish to acknowledge the role the Senator from Alaska has played, Ms. MURKOWSKI, as well as Senator KAY BAILEY HUTCHISON, Senator SNOWE, and Senator COLLINS. We, the women of the Senate, have worked on a bipartisan basis for years making sure we were included in the protocols at NIH, increasing funding for important research areas to find that cure, to race for that cure and, at the same time, to be able to have mammogram standards. What the Murkowski amendment—and by the way, she is MURKOWSKI, I am MIKULSKI. We sound alike, and the amendments might sound alike, but, boy, are they different.

The Murkowski amendment offers information. I think that is important. That is a threshold matter. You have to have information to make an informed decision. But it does not guarantee universal access to these services, and, of course, it does not eliminate the high payments and deductibles. So her amendment is flawed. My amendment is terrific. My amendment offers key preventive services, including an annual women's health screening that would go to a comprehensive assessment of the dangers to women, including heart disease and diabetes.

We hope when the Senate makes its decision today, it deals with the fact that for we women, the insurance companies take simply being a woman as a preexisting condition. We face so many issues and hurdles. We can't get health care. We can't get health insurance because of preexisting conditions called a C-section.

I am going to be meeting with an insurance company executive later where his company denied health insurance to a woman who had a medically mandated C-section, and a letter from this insurance company said: We are not going to give you insurance unless you have a sterilization—a coerced sterilization in the United States of America. That is going to be an amendment for another day. But I just wish to give the flavor and the power of what women face when we have to cope with the insurance companies or where there are barriers to our getting these health care screening services.

So we want to be able to save lives, and we want to be able to save money. We believe in universal access, and if you utilize the service it is because you have had the consultation with your doctor. We do know early screening and detection does save lives, and, at the same time, it saves money.

I will conclude with this: When we look at heart disease and diabetes, not only cancer but early detection of diabetes means, in a well-managed program, under appropriate medical supervision you very likely will not lose that eye, you will not lose that kidney, you will not lose that leg and, most of all, you will not lose your life.

So let's not lose the Mikulski amendment. Let's go with Mikulski and thank MURKOWSKI for her information, but hers is too tepid and too limited.

Madam President, I ask my colleague, one of the great guys who supports us, Senator CARDIN, how much time he needs.

I yield 5 minutes to Senator CARDIN.

Mr. CARDIN. First, let me thank my colleague, Senator MIKULSKI, for her leadership on this issue. I strongly support her amendment for the reasons she said. This is a very important point about providing preventive health services to the women of America, a critically important part of our strategy not only to bring down costs in health care, but to have a health care system that is fair in America.

I have been listening to my colleagues on the other side of the aisle talk about the underlying bill. They talk about it as if this is a static situation. Many of the criticisms I hear about the underlying bill are criticisms about our current health care system. I can tell my colleagues the people in Maryland, many of whom are finding it difficult to find affordable coverage today, are outraged with what is happening with private insurance companies and the attitudes they are taking.

As Senator MIKULSKI pointed out, they are denying coverage for preexisting conditions or imposing arbitrary caps. As has been indicated, if we are unable to get this bill passed, what is going to happen in the future? We know costs are going to become even greater, more people are going to lose their coverage, insurance companies are going to continue their arbitrary practices, and the health care of Americans is in jeopardy.

We are already spending so much of our economy on health care, and if we don't take action, it will be a greater part of our economy.

But we have some good news. The underlying bill has now been analyzed by the CBO; that is the independent scorekeeper. What they tell us is, if we pass the underlying bill, for the overwhelming majority of Americans, they are going to find that their health insurance premiums will either stay the same or go down. For the overwhelming majority of Americans, they will have a better insurance product that will cover the types of preventive services Senator MIKULSKI is talking about, which are in her amendment.

We are not only going to bring down the cost for the overwhelming majority of Americans as to what will happen if we don't pass a bill, we are going to provide better coverage for them. The underlying bill will also reduce dramatically the number of people who don't have health insurance in America by 31 million. That will make our system much more effective.

I have heard my colleagues talk about what is going to happen with Medicare. If we pass the underlying bill, we are going to strengthen Medicare. We already have a provision that there cannot be reductions in the guaranteed benefits. We pointed out that AARP endorses the bill. They understand there will be additional preventive health care for our seniors, and we will help fill the doughnut hole in prescription drugs.

When you reduce the number of uninsured, the amount of cost Medicare has to pay for health care in our hospitals is reduced. That is why we can reduce our payments to hospitals in America, because the amount of uncompensated care they currently have will be dramatically reduced. I have heard colleagues on the other side of the aisle talk about Medicare Advantage. I remember when we used to pay the private insurance companies in Medicare a little less than people in traditional Medicare. Then we paid them the same. Now we are paying them more. That is corporate welfare. Medicare Part B premiums are higher than they should be. Taxpayer support is higher than it used to be. We know these benefits that are being paid could be gone tomorrow. We saw the private insurance companies leave the Maryland market and so many other markets. These are reforms that save the taxpayers money and strengthen Medicare for the future.

Bottom line: The bill is good for middle-income families. It will provide the insurance reform so they have an insurance product that can cover their needs, including wellness and prevention programs. It is good for small business because it offers more choice. I can tell you chapter and verse of small companies in Maryland that, today, cannot get an affordable product and are seeing 20, 30 percent increases in their premiums. They need this bill in order to be able to preserve health care for their employees.

This bill, with the Mikulski amendment, will provide the preventive health care for all Americans that is so desperately needed, which will reduce costs, improve quality, and make our health care system more efficient and effective in the future, bringing down costs by investing in wellness and prevention.

I urge my colleagues to support the Mikulski amendment and to support the underlying bill.

I yield the floor.

Mr. ENZI. Madam President, I yield 10 minutes to the Senator from South Dakota.

The ACTING PRESIDENT pro tempore. The Senator from South Dakota is recognized.

Mr. THUNE. Madam President, I appreciate the opportunity to speak on this important piece of legislation.

Again, I point out to my colleagues, and to anybody else who may be observing, the volume of this bill. This is 2,100 pages and 21 pounds, which means it is about a pound per 100 pages. It is $1.2 billion dollars per page, $6.8 million per word, and it creates 70 new government programs. It gives the Secretary of Health and Human Services—in 1,600 or 1,700 instances in this bill—the opportunity to create, define, and determine things in the bill.

This is a big government bill, a massive expansion of the Federal Government—$2.5 trillion, when it is fully implemented. Of course, the paid-fors in the bill—all the things in this bill, not only those intended things but also the unintended consequences of the bill—you have some revenue to pay for these things. Where do we get the revenue?

In the Reid bill, they decided they are going to raise taxes on small businesses, individuals and families and they are going to cut Medicare by about $½ trillion.

What is ironic about that is, a few years ago, the Republicans, back when we were in the leadership in the Senate, tried to do a budget bill that actually achieved some savings in Medicare and Medicaid, to the tune of $27 billion combined. But the Medicare savings in that bill was $10 billion. That was over a 5-year period, at $2 billion per year. I wish to remind some of my colleagues on the other side about some of the comments they made about that.

Senator REID, at the time—bear in mind this was to reduce Medicare by $2 billion per year, $10 billion over 5 years. The now-majority leader said:

> Unfortunately, the Republican budget is an immoral document.

The Senator from West Virginia said this:

> This proposed budget would be a moral disaster of monumental proportions.

A couple other colleagues in the Senate commented. The Senator from Michigan said:

> People who rely on Medicare and Medicaid are going to be hurt by this bill.

The Senator from Wisconsin said:

> I urge my colleagues to reject this bill, and the irresponsible and cruel budget of which it is part.

The former Senator from New York, Mrs. Clinton, said this:

> This bill slashes $6.4 billion from Medicare over the next 5 years.

It was actually $10 billion. My point is simply this: It was $10 billion over 5 years, $2 billion per year. Those were the statements—overstatements—about the impact that a $2 billion reduction per year in Medicare was going to have on people in this country. Now we are talking about $½ trillion in Medicare cuts.

Where do their cuts come from? They will come from $118 billion from Medicare Advantage, which now we have about 11 million Americans impacted by Medicare Advantage. Every State has seniors who have subscribed to that program whose benefits will be cut if this bill is enacted. You get it out of hospitals because there are $135 billion in reductions and reimbursements to hospitals; $15 billion in reductions to nursing homes and reimbursements; $40 billion in reductions to home health agencies; and $8 billion in reductions to hospices.

Those are all the ways this $2.5 trillion expansion of the Federal Government is to be paid for. I didn't even get into the tax cuts, which will be a debate for another day.

The Medicare cuts in this bill are unlike anything we have seen in the past.

Clearly, when you compare it to 3, 4 years ago, when we were trying to achieve $10 billion in savings over 5 years, you thought the sky was falling. Now here they are trying to pay for a $2.5 trillion expansion of the Federal Government by cutting $500 billion out of Medicare.

The point I also wish to make, because it has been made by the other side—by the most recent speaker—is that somehow this recent CBO analysis should be hailed as good news. The corks are popping in the celebration, and people are crowing about the new CBO report because it has such good news for this bill and the impact it will have on people who buy health insurance in this country.

What is it they are celebrating? CBO, in its report, essentially said this: 90 percent of Americans are going to see their premiums increase or see virtually the same increases as they do today year after year.

That is preserving the status quo, not decreasing costs, as promised. President Obama, when he was running for office in 2007, said when he got a chance to do health care reform, he was going to reduce costs by $2,500 for every family in this country and cover everybody.

This bill, after spending $2.5 trillion and creating 70 new government programs, doesn't cover everybody. There are still 24 million Americans who don't get covered under this bill, according to the CBO. Furthermore, nobody—I shouldn't say nobody—90 percent of Americans, those who don't get subsidies, don't come out any better. They will still see the year-over-year increases in premiums they have been seeing for the past several years, and the cost of health care is growing at twice the rate of inflation. If you assume a year-over-year increase similar to the past several years, in the small group market, you are looking at annual increases of over 6 percent for the cost of health care—to the point where a family that, today, is paying $13,000 a year for health insurance, in 2016, will pay over $20,000 a year for health insurance. So nobody gets any better out of this, except a handful of people who will get subsidies. If you are in the individual marketplace, your premiums go up. According to the CBO, there will be a 10- to 13-percent increase in premiums in the individual market. If you are in the large group market, you will see an almost 6-percent increase a year. If you are in the small group market, premiums will go up over 6 percent a year.

We are talking about spending $2.5 trillion, cutting reimbursements to nursing homes, to hospitals, to home health agencies and hospices, and raising taxes on health care providers, medical device manufacturers, prescription drugs, raising the Medicare payroll tax which, incidentally, doesn't go to preserve or extend the lifespan of Medicare or put it on a path toward sustainability but creates a whole new government entitlement.

We are going to do all that for what? At best, to keep the status quo for people today; at worst, to increase their premiums by 10 to 13 percent. That is the bottom line. That is what this says. That is the new CBO report. That is the CBO report about which the other side is saying this is great news. They are celebrating. It is great news that premiums are going to continue to go up at twice the rate of inflation, just like in the past, protecting and preserving the status quo as we know it in America today.

This bill does nothing about the fundamental issue of cost. It doesn't matter what market you are in—small group market, large group market—it stays the same, at best, and in the individual marketplace, your premiums will go up 10 to 13 percent. That is the news being hailed by the other side as validating the argument for why we need to pass a 2,100-page, $2.5 trillion monstrosity of a bill with 70 new government programs in it.

We will vote on the Medicare amendment later. Senator MCCAIN has a motion to commit the bill to essentially take the Medicare cuts out of it. I hope my colleagues vote for it. They are arguing it doesn't cut Medicare. How can you say that with a straight face? How can you say you are going to find $500 billion to pay for this bill out of Medicare and then say it doesn't cut Medicare? Of course it cuts Medicare. Of course it raises taxes. You can't finance $2.5 trillion of new spending unless you find a way to finance it.

The way they have chosen to finance this is to hit seniors squarely between the eyes and cut reimbursements to the providers all across this country that are dealing with the serious health needs our senior citizens are experiencing. In South Dakota, we have a lot of people who are employed in the health care industry. I think that is true of every State. Even in small towns in South Dakota, in nursing home employment you are talking about almost 6,000 employees. You are going to take $15 billion out of nursing homes, $40 billion out of home health agencies, $135 billion out of hospitals, and what we are talking about are huge reductions in Medicare, unlike anything we have seen.

As I said, to put it into perspective, a few short years ago, when we were in the majority, in a budget trying to reduce Medicare by $10 billion over a 5-year period, it was referred to as ''immoral,'' as a ''monumental disaster,'' as ''cruel''—$10 billion over 5 years. This has $½ trillion in Medicare cuts—cuts to Medicare Advantage and providers.

I hope my colleagues will support the McCain motion.

I yield the floor.

Ms. MIKULSKI. Madam President, I yield 3½ minutes to the junior Senator from Minnesota, Mr. FRANKEN.

The ACTING PRESIDENT pro tempore. The Senator from Minnesota is recognized.

Mr. FRANKEN. Madam President, I rise to express my support for Senator MIKULSKI's amendment for women's health.

This amendment is crucial because it is about prevention. Prevention is one of the key ways this bill will transform our system of sick care into true health care. It is common sense. You get the right screenings at the right time so you find diseases earlier. It saves lives and it saves money.

The Senate bill already has several provisions for preventive care, which I strongly support. For example, colonoscopies and screening for heart disease will be covered at no cost. It is a good start.

The current bill relies solely on the U.S. Preventive Services Task Force to determine which services will be covered at no cost. The problem is, several crucial women's health services are omitted. Senator MIKULSKI's amendment closes this gap. Under her amendment, the Health Resources and Services Administration will be able to include other important services at no cost, such as the well woman visit, prenatal care, and family planning.

These preventive services will truly improve women's health. For example, if all women got the recommended screening for cervical cancer, we could detect this disease earlier and prevent four out of every five cases of this invasive cancer. This will improve the health of our mothers, sisters, and our daughters. This bill and this amendment will make prevention a priority and not an afterthought.

Although I respect the efforts of my distinguished colleague from Alaska, the Murkowski alternative falls short. The Murkowski amendment does nothing to guarantee women will have improved access to coverage and cost-sharing protections for preventive services. Rather than establish objective, scientific standards about which preventive services should be covered, this alternative only requires insurers to consult with medical organizations when making coverage decisions.

While we know the U.S. Preventive Services Task Force recommendations do not cover all necessary services, the Murkowski amendment entirely removes even this basic coverage requirement from the bill, leaving women without any protections under health care reform for essential preventive care. This means that important preventive care for women, including screening for osteoporosis and sexually transmitted infections, may not be covered by insurance plans.

In the simplest terms, the Murkowski amendment maintains the status quo, and we know the status quo is not working for millions of women who are forgoing preventive care because they simply cannot afford it. The Murkowski amendment continues to leave prevention coverage decisions up to health insurance companies, and that means there would be no guarantee

that any health plan will cover basic preventive services at all.

Do we want to leave these important decisions up to the insurance companies? The health of American women is too important to leave in their hands. That is why I urge my colleagues to support Senator MIKULSKI's amendment and vote to make sure women can get the preventive screenings they need to stay healthy. Most important, this amendment will make sure women have access to these lifesaving screenings at no cost.

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

Mr. FRANKEN. I request another 45 seconds.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. FRANKEN. Madam President, prevention is just one of the ways this bill will improve women's health. It also ends insurance companies' practice of charging women more because they happen to be women, or denying coverage based on a history of pregnancy, C-section, or domestic violence.

We need to pass this bill this year to ensure comprehensive, affordable care for women throughout the country. And we need to include this amendment because I want to be able to look my wife in the eye, I want to be able to look my daughter in the eye—my son, too—and my future grandchildren in the eye and say we did everything we could in this bill to improve women's health. We cannot wait any longer. I urge all my colleagues to stand with us and support this amendment.

I yield the floor.

Mr. ENZI. Madam President, I yield 5 minutes to the Senator from Oklahoma.

The ACTING PRESIDENT pro tempore. The Senator from Oklahoma.

Mr. COBURN. Madam President, it is interesting, as a practicing physician who has actually cared for women and nobody so far who has been in on this debate has ever done. I congratulate the Senator from Maryland for her care about prevention because we all know that is key.

The mischaracterization we heard about this bill is astounding. The reason we got in trouble with the Preventive Task Force is because it did something that was inappropriate and did not have the appropriate professional groups on its task force when it made its recommendation on breast cancer screening.

The Murkowski amendment says we will rely on the professional societies to make the determinations of what must be available. We have heard the Senator from Iowa say health insurance will decide that. That is absolutely untrue. Health insurance will not decide it. The professional societies will decide what will be covered, and the insurance companies must cover it under the Murkowski amendment.

The second point is there will not be any objective criteria. The objective criteria doctors practice under today are the guidelines of their professional societies.

Here is the difference between the Murkowski amendment and the Mikulski amendment: The Senator from Maryland relies on the government to make the decision on what will be covered. She refers to the Health Resources and Services Administration. She refers to the Health Resources and Services Administration which has no guidelines whatsoever on women's health care right now, other than prenatal care and childcare. That is the only thing they have.

For whom does HRSA work? HRSA works for the Secretary of Health and Human Services. So the contrast between these two amendments could not be any more clear in terms of do we want to solve the problems we just experienced on mammogram recommendations? We can let the government decide, which got us into this trouble, and they will set the practice guidelines and recommendations for screening or you can let the American College of Obstetricians and Gynecologists or the American College of Surgeons or the American College of Oncologists set and use their guidelines.

The choice is simple: The government can decide what care you get or the people who do the care, the professionals who know what is needed, who write the peer-reviewed articles, who study the literature and make the recommendations for their guidelines.

Every month I get from the American College of Obstetricians and Gynecologists their new guidelines. I try to follow them at every instance. The fact is, the Mikulski amendment says government will decide. That is what it says. The government will decide through HRSA. The Murkowski amendment says it is the best practices known by the physicians who are out there practicing. What is the difference? How does it apply to you as a woman? It applies to you as a woman because the people who know best get to make the recommendations rather than a government bureaucracy. That is the difference.

If you will recall, under the stimulus bill we passed, we have a cost comparative effectiveness panel, which will surely be in the mix associated with the recommendations. If you look at what the task force on preventive recommendations said from a cost standpoint, they were absolutely right. From a patient standpoint, they were absolutely wrong.

The real debate on this bill—the Mikulski amendment is the start of the real debate—is do we have the government decide based on cost or do we have the professional caregivers who know the field decide based on what is best for that patient. That is the difference.

What the Senator from Alaska does, which is necessary, is she says we will rely on the American College of Obstetrics and Gynecology. We will rely on the American College of Surgeons. We will rely on the American College of Oncologists to determine what should be the screening recommendations for patients.

For, you see, what happens with the Mikulski amendment is the government stands between you and your doctor. That is what is coming. That is what will be there.

There is no choice under the Murkowski amendment for an insurance company to have the option either to cover or not to cover. They must. It says ''shall'' do that. So the mischaracterizations on what the Murkowski amendment actually says and does are unfortunate.

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

Mr. COBURN. I yield the floor.

The ACTING PRESIDENT pro tempore. Who yields time?

The Senator from Maryland.

Ms. MIKULSKI. Madam President, how much time does our side have?

The ACTING PRESIDENT pro tempore. There is 17 minutes 15 seconds remaining.

Ms. MIKULSKI. I yield 5 minutes to the Senator from Michigan.

The ACTING PRESIDENT pro tempore. The Senator from Michigan.

Ms. STABENOW. Madam President, first, I thank Senator MIKULSKI for her leadership not only on this important amendment but on so many issues in health care, issues for women across this country. We are honored to call her dean for all of us as it relates to focusing on the issues that are so critical to women and their families.

I thank Senator REID for making this a priority and making this the first amendment we are offering in this debate.

We all know that often women are the ones making health care decisions for their families as well as themselves. They are more likely to be the person making health insurance choices. Women of childbearing age pay on average 68 percent more for their health care than men do. We have so many instances in which insurance companies are standing between women and their doctors right now in making decisions—decisions not to cover preventive services, such as a mammogram screening or a cervical cancer screening, decisions to call pregnancy a preexisting condition so women cannot get health insurance, decisions not to cover maternity care so that women and their babies can get the care they need so that babies can be successful in life, both prenatal care and postnatal care.

Women of this country have a tremendous stake in health care reform. We pay more now, if we can find coverage at all, and there are too many ways in which insurance companies block women from getting the basic health services they need.

This amendment is critically important to make sure that women are able

to get preventive care services without a deductible and without copays. This amendment recognizes the unique health needs of women. It requires coverage of women's preventive services developed by women's health experts to meet the unique needs of women.

Why do we stress that? We stress that because for years we have struggled in so many areas to make sure that women's health needs were focused on and not just health in general. When we look at research through the National Institutes of Health and what it took to get to a place where research would be done for women on women's subjects or on female mice or rats rather than male subjects to make sure that the differences between men and women were considered in research, we have made important steps in that direction. Again, Senator MIKULSKI was leading the way as it relates to having a women's health research effort in our country.

This is one more step to make sure we are covering women's preventive services developed by women's health experts for the unique needs of women. That is what this is all about—making sure women have access to preventive services such as cervical cancer screenings, osteoporosis screenings, annual mammograms for women under 50, pregnancy and post partum screenings, domestic violence screenings, and annual checkups for women.

We know more women die of heart disease than actually any other disease. This is something I do not think is widely known. We have even heard that many physicians do not realize the extent to which heart disease is prevalent in women. All of us women have worked together on a women's heart bill and part of that is for screenings. Part of that is to make sure we are screening for heart disease and strokes, the No. 1 killer of women. This would make sure those screenings would be part of health care reform.

I could go on to list all the different prevention items, but I will simply say that when we are talking about women's health and we are talking about women's lives, this is an incredibly important amendment to adopt.

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

Ms. STABENOW. I yield the floor.

Mr. ENZI. Madam President, I yield 5 minutes to the Senator from Texas.

The ACTING PRESIDENT pro tempore. The Senator from Texas.

Mrs. HUTCHISON. Madam President, I rise to speak on the Mikulski amendment and the Murkowski amendment because I feel very passionate about women's issues. In fact, Senator MIKULSKI and I have worked throughout my time in the Senate and her time before me on these very issues—assuring that women's health care concerns, which are different from men's in many instances, are a part of any health care coverage in our country, and ongoing we must assure the same.

I have been an advocate for cancer screening services for women, and I was dismayed when I saw the U.S. Preventive Services Task Force a few weeks ago issuing new guidelines for cancer screening for women—breast cancer screening for women. We have all lived with breast cancer throughout the course of the history of women, but especially in the last probably 25 years the strides that we have made in saving lives and in the survivability of women with breast cancer is because we have had early detection. We don't have a cure for breast cancer, and we are all fighting for that cure, but until we get it, the first line of defense is early detection.

So now we have a new task force recommendation that says everything we have had and enjoyed over the last 25 years in saving women's lives is no longer relevant because now, before the age of 50, you don't need a mammogram, and after the age of 50 it is every other year.

Well, I know Senator MIKULSKI and I agree we do not think that is right. Neither did any other woman in the Senate when that was proposed years ago by President Clinton. We all stood up and said no. I am standing up and I am saying no once again, and I am sure every woman in the Senate is, as many women in America are.

But the Mikulski amendment doesn't actually fully address the problem of having the task force—which is relied on 14 times in the bill before us—as the arbiter of what is necessary for our government program and that it then will surely become the private sector standard as well. That task force even has money allocated to advertize its task force recommendations. So rather than the Mikulski amendment severing the ties with the task force, the amendment now has another government agency that has the same capability to basically interfere between the woman and her doctor, which is where we want the decisions to be made. Coverage decisions will be dictated by both the task force and a new Health Resources and Services Administration entry into the mix.

While I certainly agree with Senator MIKULSKI about the importance of preventive services for women and insurance coverage decisions, I can't support her amendment because we still have not one but two government task forces and committees that will be in the middle of these health care coverage decisions. I think the coverage decisions should be made by doctors and their patients. That is why I have joined with Senator MURKOWSKI in offering the alternative approach. This is what we should expect from any future health care reform, and it is certainly what we expect today.

The Murkowski amendment will leave the medical decisions to the guidelines established by those who know medical treatment best, which is our own doctors. In fact, we have just received a CBO assessment of what the Murkowski amendment would cost, and it actually says there will be a savings. So rather than the Mikulski amendment, which would spend $1 billion over 10 years, the Murkowski amendment would actually save $1.4 billion over 10 years. Why? Because the Murkowski amendment relies on the combined commonsense and clinical judgment of American physicians.

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

Mrs. HUTCHISON. So, Madam President, I urge a vote for the Murkowski amendment. I know we have the same goals as Senator MIKULSKI and her amendment, but I don't believe the Mikulski amendment achieves the goal of having a woman and her doctor make the decisions for her. That is the key that I think is so important in this debate. I urge a vote for the Murkowski amendment.

I thank the Chair, and I yield the floor.

The ACTING PRESIDENT pro tempore. Who yields time?

Ms. MIKULSKI. Madam President, I yield 4 minutes to the Senator from the State of Washington, who has been a real leader on these issues.

By the way, Madam President, before the Senator speaks, I want to thank Senator STABENOW for a unique courtesy. This is her desk, and as many of my colleagues know, I broke my ankle and I can't get up to where my desk is at this point. I will, however, in a matter of another few weeks. But she has given me this desk on loan so that I could stand on my own two feet to debate this amendment, and I wanted to thank her for the courtesy.

Madam President, I also want to note something while the senior Senator from the Republican leadership is here, and the author of the amendment. We, the women of the Senate, on a bipartisan basis, have worked for women's health. Today, we disagree on what is the best way to achieve it by these two amendments. I want to thank my colleagues for setting a tone of civility. I think this has been one of the most rational, civilized conversations we have had over this, and I would like to thank them.

As the leader on this side of the aisle, in terms of seniority, I would like to extend my hand in friendship and suggest when this bill is done, and this amendment is done, we continue to focus on this wonderful work that we have done together. We have done things that have saved millions of lives, and so I look forward to continuing that.

Madam President, I now yield 4 minutes to the Senator from the State of Washington, Mrs. MURRAY.

The ACTING PRESIDENT pro tempore. The Senator from Washington.

Mrs. MURRAY. Madam President, I thank my colleague from Maryland, and I would just say that wherever she stands on the floor of the Senate, she leads us all. So we are delighted you are here and thank you so much for

your leadership on this critical issue of making sure women have access to quality preventive health care services and screenings which are so critical to women across the country.

Madam President, the Senator from Maryland offered this amendment, and I worked with her in the committee. She has been a leader on this for many years, and I echo her comments as well that this has always been an issue. For as long as I have been here—since 1993—the women in the Senate, on both sides of the aisle, have stood up to make sure that women's care is part of health care, and we understand we have to stand shoulder to shoulder. It is unfortunate at this time that we see this in a little different light, but I agree with Senator MIKULSKI. We will keep working together throughout our time here to make sure women's preventive services are covered.

I do support the Mikulski amendment and the MIKULSKI approach. Her amendment requires all health plans to cover comprehensive women's preventive care and screenings at no cost to women. I just wanted to come to the floor for a minute and point out why this is so important.

When the economy is hurting, women on the whole tend to think of caring for their families first and not caring for themselves. They take care of their children and their spouses first, and they end up delaying or skipping their own health care in order to take care of their families. In fact, we know in 2007, a quarter of women reported delaying or skipping their health care because of cost. In May of 2009, just 2 years later, a report by the Commonwealth Foundation found that more than half of women today are delaying or avoiding preventive care because of its cost.

That is not good for women, it is not good for their families, and it is not good for their ability to be able to take care of their families and to take care of themselves. So Senator MIKULSKI's amendment is extremely important, especially in this economic time. We know if women get the preventive care and care for their needs, then they are able to care for their families. Yet the situation we find ourselves in today is that women are not taking preventive care. They are not taking care of themselves. Therefore, when they get sick, they end up in the hospital and then their families are in trouble. So we know preventive services can save lives, and it means better health outcomes for women.

We have to make sure we cover preventive services, and this takes into account the unique needs of women. Senator MIKULSKI's amendment will make sure this bill provides coverage for important preventive services for women at no cost. Women will have improved access to well-women visits—important for all women; family planning services; mammograms, which we have all talked about so many times, to make sure they maintain their health.

Madam President, I want to emphasize that this amendment preserves the doctor-patient relationship and allows patients to consult with their doctors on what services are best for them. This has become a large topic of conversation over the last several weeks, and Senator MIKULSKI's amendment makes sure if a woman under 50 decides to receive an annual mammogram, this amendment will cover it. She will be able to work with her own doctor and take care of her health.

So, Madam President, I come to the floor today to strongly support the Mikulski amendment, to thank her for her leadership, and I hope we can get to and vote on this important issue and move on and pass health care reform.

My constituents, when I go home, say: Move on. Get this done. We have to take care of this because of our economy, because of the impact on small businesses, because of the rising costs of premiums, and because of the large number of people who are losing their health care coverage. This health care bill is going to make a major difference when we get it passed, and the American public can take a deep breath and say: Finally, our government has moved forward.

So let's get past this amendment. I support strongly the Mikulski amendment. Let's move on this bill and take a major step forward for health care coverage for all Americans and pass the health care bill.

Madam President, I yield the floor.

ABORTION

Mr. CASEY. Madam President, may I ask the Senator from Maryland to yield for a question about her amendment, No. 2791 to H.R. 3590, the purpose of which is to clarify provisions relating to first dollar coverage for preventive services for women?

Ms. MIKULSKI. Of course.

Mr. CASEY. Senator MIKULSKI had a similar amendment in the HELP Committee bill and at that time, I commended the Senator on its substance as I am a strong supporter of preventive care for women. I thank her for offering this important amendment and particularly for calling our attention to the importance of first dollar coverage of preventive services for women.

Ms. MIKULSKI. I thank the Senator.

Mr. CASEY. Particularly in view of some of the recent controversy about mammograms and coverage, I am particularly grateful that the Senator has clarified this with this amendment and allow for the fact that preventive services must preserve the doctor-patient relationship. Thus, women under 50 may decide with their doctor that they should have a mammogram screening and this amendment would ensure coverage of such service.

Ms. MIKULSKI. That is correct.

Mr. CASEY. There is one clarification I would like to ask the Senator. I know we discussed it during the HELP markup and it was not clarified at that time and thus I chose to vote against the amendment because of the possibility that it might be construed so broadly as to cover abortion. But I understand that the Senator has now clarified specifically that this amendment will not cover abortion in any way. Specifically, abortion has never been defined as a preventive service and there is neither the legislative intent nor the language in this amendment to cover abortion as a preventive service or to mandate abortion coverage in any way. I ask the Senator is that correct?

Ms. MIKULSKI. Yes, that is correct. This amendment does not cover abortion. Abortion has never been defined as a preventive service. This amendment is strictly concerned with ensuring that women get the kind of preventive screenings and treatments they may need to prevent diseases particular to women such as breast cancer and cervical cancer. There is neither legislative intent nor legislative language that would cover abortion under this amendment, nor would abortion coverage be mandated in any way by the Secretary of Health and Human Services.

Mr. ENZI. Madam President, I yield 2 minutes to the Senator from Kansas.

Mr. BROWNBACK. Madam President, I rise in support of the amendment of the Senator from Alaska, and I have talked with my good friend, the Senator from Maryland, Ms. MIKULSKI, about a side issue in this overall debate about what is included in the definition of preventive care. The Senator from Maryland stated in a colloquy that ''there are no abortion services included in the Mikulski amendment.'' She has stated that in colloquy.

I have trouble, however, because I believe a future bureaucracy could interpret it differently. So I asked my friend from Maryland if she would include clear legislative language in this saying simply:

> Nothing in this Act shall be construed to authorize the Secretary, or any other governmental or quasi-governmental entity, to define or classify abortion or abortion services as ''preventive care'' or as a ''preventive service.''

I think that clarifies the issue, and it would be my hope that my colleague from Maryland would include that in her language. It is not in there, even though there have been statements on the floor. But, as we all know as legislators, it is one thing to say something on the Senate floor, and it is one thing to have a colloquy, but it is far different to have it written in the base law. This is not in the base law.

So I would urge my colleague, the Senator from Maryland, to include this language. Absent that, I think there is too much room for a broader definition of what preventive care means; that it could include abortion services as well, and I would urge my colleagues to vote against the Mikulski amendment if that is the case.

On that ground, I think there are other issues involved, and that is why I think the approach of the Senator from

Alaska is superior, while maintaining the doctor-patient privilege. I think this is a good debate for us to have, given these recent discussions. But absent this change, I think there is another issue that is involved that I would urge my colleagues to consider.

Madam President, I want to yield back to maintain some time for the Senator from Wyoming to be able to speak, so I yield the floor.

Mr. FEINGOLD. Madam President, disappointed that the Senate health care debate has gotten off on the wrong foot. The first amendment voted on would add almost a billion dollars to our budget deficits over the next 10 years. We should make sure health plans cover women's preventive care and screenings, but we should also find a way to pay for it, rather than adding that cost to the already mountainous public debt. At a time of record deficits, Americans expect fiscal responsibility from their representatives in Congress.

The PRESIDING OFFICER (Mr. KIRK). Who yields time?

Ms. MIKULSKI. Mr. President, we are waiting for Senator BOXER to come to the floor, so if the other side of the aisle has another speaker, I know at the end we hope that Senator LISA and Senator BARB—I say that because our last names sound so much the same—could wrap it up.

How would the Senator from Wyoming like to proceed? We are waiting for Senator BOXER or for Senator BAUCUS.

Mr. ENZI. Mr. President, I yield 10 minutes to the Senator from Alaska so she can actually propose her amendment that we have been debating and take up to 10 minutes.

Ms. MIKULSKI. Then I will wrap up.

Mr. ENZI. That would still leave us with 2 minutes. If it does leave us with 2 minutes, then I would have the Senator from Wyoming use that 2 minutes.

Ms. MIKULSKI. Whatever way it will work and accommodate you while we are waiting to see who our speakers are.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Ms. MURKOWSKI. Mr. President, I want to start my comments by acknowledging my colleague from Maryland and accept her gracious offer to continue to work on this issue as it relates to women's health and women's health services. As has been noted by the Senator from Maryland and the Senator from Washington, this is an issue that we women of the Senate have come together on repeatedly, to work cooperatively. While we do have, some would say, somewhat dueling amendments here, I think it is important to recognize the goals we are both seeking to attain here are certainly right in alignment. We are just choosing different means to get there. But I appreciate, again, the civility and cooperation from not only Senator MIKULSKI but the other women of the Senate on this very important issue.

I wish to reiterate a couple of points about my amendment that I made yesterday.

The PRESIDING OFFICER. The Senator from Maryland.

Ms. MIKULSKI. Mr. President, I fear the microphone of the Senator from Alaska is not working.

Ms. MURKOWSKI. Is that better?

Ms. MIKULSKI. That is so much better. I want to hear about the amendment and continue our conversation.

Ms. MURKOWSKI. The Senator just missed all the kind remarks I directed to her attention.

Ms. MIKULSKI. I ask unanimous consent she be extended an additional 2 minutes. No, I withdraw that request.

Ms. MURKOWSKI. I will make sure those comments that were made for the RECORD will be delivered to the Senator personally.

I want to reiterate some points I made yesterday about my amendment and I will also share with my colleagues, I know the Senator from Texas mentioned it as well, the CBO score we received late last evening. It provides us with a score showing a cost savings of $1.4 billion over the next 10 years. I think this is significant, as Members, certainly from the other side, raised the importance of fiscal discipline and our fiduciary responsibility here. Importantly, the CBO indicated the provisions on the second page which prevent the Secretary from using the recommendations of the USPSTF to deny coverage would cost money which means we are protecting certain benefits and that is very important.

The amendment we will have before us, the Murkowski amendment, is one that allows or requires a level of transparency with the recommended health screenings, prevention services that are deemed necessary not by some task force that is appointed by folks within the administration, not by some commission that has political relationships. What we are urging is that the health screenings, the preventive services, be determined by those who are actually in the field, those practitioners—those who are engaged in oncology, OB/GYNs. We need to be looking to the experts. We need to be looking to that peer-reviewed science. We don't need to be looking to those entities that have been brought together by a government entity or by the Secretary. We need to be looking to the likes of the American Society of Clinical Oncology, the American College of Surgeons, the American College of Radiation Oncology, the American College of Obstetrics and Gynecology. We need to look to their recommendations.

Again, as I mentioned yesterday in my comments, if you go to their Web sites, if you look to their specific recommendations, they will give guidance, guidance that, again, is based on their practice in oncology, their practice as an OB/GYN. Look to what they set out as the guidelines for cervical cancer screening, for mammograms, and let that information be made available publicly through the pamphlets, the plans that come together from the insurance companies. But allow them—allow me, as a consumer of health care, me as a consumer looking for the best plan for me and my family—to know what those guidelines are, not from a government task force but from those who are the real experts. I think this is the transparency that health care shoppers are looking for.

Some have suggested: LISA, your amendment doesn't require the insurance companies to provide any prevention or screening services. There is no mandate in there. If we do not have a mandate, then the insurance companies are not going to provide health care prevention and screening services.

I think we need to ask the question here, what is the point of prevention? It is to prevent more expensive care in the future by preventing the chronic and more acute illnesses. So should not the insurance companies want to utilize more preventive services, utilize more screenings, more wellness services, in order to keep down the costs of care based on the judgment of the doctors, based on the judgment of the professionals, and not necessarily those who, again, are part of a government entity?

I know within my staff I have a member who is on the FEHBP plan, but they contact her on a somewhat regular basis about her diabetes care, ensuring she is taking her medications, getting the necessary preventive services offered by her insurer for her particular condition.

It has been mentioned by several of my colleagues that this USPSTF is not such a bad group of guys, they are not just these nameless, faceless bureaucrats. I think it is important to recognize, and even the American Heart Association has recognized it, that the Preventive Services Task Force is limited to only primary care doctors and not specialists such as the oncologists, the cancer doctors who see patients every day battling cancer. These doctors who are providing Americans with their suggestions on what services are necessary for cancer screenings, but yet these doctors are not part of this task force, have again shone the spotlight on what happens when you have a government entity or government task force that is basically the one saying this is what is going to be covered, this is not what is going to be covered. In my amendment, we specifically provide that the recommendations from USPSTF cannot be used to deny coverage of an item or service by a group health plan or health insurance offeror. I think that is very important.

I think it is also important to recognize that what we do in my amendment is make sure the health plans consult the recommendations and guidelines of the professional medical organizations to determine what prevention benefits should be covered by these health insurance plans throughout the country.

We also require plans to provide this information directly to the individuals. You get to see it for yourself. You get to make that determination. So what that means is the doctors and the specialists will be recommending what preventive services to cover, not those in Washington, DC.

My amendment ensures that the Secretary of Health and Human Services shall not use any of the recommendations, again made by the task force, to deny coverage. We also include broad protections to prevent bureaucrats at the Department of Health and Human Services from denying care to patients based on comparative effectiveness research. And finally, we have a provision that ensures the Secretary of Health and Human Services may not define or classify abortion or abortion services as preventive care or as preventive services.

The PRESIDING OFFICER. The time of the Senator has expired.

Ms. MURKOWSKI. I appreciate that. I think my amendment is straightforward. I think it is a good compromise and again it is a clear differential between what we are going to do to allow a woman to have full choice with her doctor as opposed to government telling us who we should be seeing.

AMENDMENT NO. 2836 TO AMENDMENT NO. 2786

Mr. President, I ask consent to call up my amendment, No. 2836.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Alaska [Ms. MURKOWSKI] for herself, Mrs. HUTCHISON, and Mr. JOHANNS, proposes an amendment numbered 2836 to amendment No. 2786.

Ms. MURKOWSKI. I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To ensure patients receive doctor recommendations for preventive health services, including mammograms and cervical cancer screening, without interference from government or insurance company bureaucrats)

On page 17, strike lines 11 through 14.

On page 17, line 15, strike ''(2)'' and insert ''(1).''

On page 17, line 20, strike ''(3)'' and insert ''(2)''.

On page 17, between lines 24 and 25, insert the following:

''Notwithstanding any other provision of law, the Secretary shall not use any recommendation made by the United States Preventive Services Task Force to deny coverage of an item or service by a group health plan or health insurance issuer offering group or individual health insurance coverage or under a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f))) or private insurance.

''(b) DETERMINATIONS OF BENEFITS COVERAGE.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, in determining which preventive items and services to provide coverage for under the plan or coverage, consult the medical guidelines and recommendations of relevant professional medical organizations of relevant medical practice areas (such as the American Society of Clinical Oncology, the American College of Surgeons, the American College of Radiation Oncology, the American College of Obstetricians and Gynecologists, and other similar organizations), including guidelines and recommendations relating to the coverage of women's preventive services (such as mammograms and cervical cancer screenings). The plan or issuer shall disclose such guidelines and recommendations to enrollees as part of the summary of benefits and coverage explanation provided under section 2715.''.

On page 17, line 25, strike ''(b)'' and insert ''(c)''.

On page 18, lines 3 and 4, strike ''or (a)(2)''.

On page 18, line 4, strike ''(a)(3)'' and insert ''(a)(2)''

On page 18, line 11, strike ''(c)'' and insert ''(d)''.

On page 124, between lines 22 and 23, insert the following:

(d) RULE OF CONSTRUCTION WITH RESPECT TO PREVENTIVE SERVICES.—Nothing in this Act (or an amendment made by this Act) shall be construed to authorize the Secretary, or any other governmental or quasi-governmental entity, to define or classify abortion or abortion services as ''preventive care'' or as a ''preventive service''.

On page 1680, strike lines 10 through 12, and insert the following:

''(A) to permit the Secretary to use data obtained from the conduct of comparative effectiveness research, including such research that is conducted or supported using funds appropriated under the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), to deny coverage of an item or service under a Federal health care program (as defined in section 1128B(f)) or private insurance; or''.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I am going to speak very briefly on the pending subject and then let the sponsor of the amendment, that is the Mikulski amendment, finish up here. I think it is very telling—I know this point has been made before but I think it bears repeating—the American Heart Association, American Stroke Association has written and released to the Senate this letter. I will read the most important part here. Basically they say they strongly support requiring health plans and Medicare providing first dollar coverage for clinical preventive services that are evidence based and necessary for the prevention or early detection of an illness or disability. We all agree with that.

They go on then to comment on the Murkowski amendment, saying they appreciate the Murkowski amendment recognized the value of the guidance and recommendations but they go on to say that even these guidelines must be held to a standard of being evidence based.

I might say, I run across this over and over again in the medical profession—medical experts. We need to keep moving more and more toward evidence-based medicine.

This statement from the American Heart Association, American Stroke Association, goes on to say:

In addition, we are concerned that Senator Murkowski's preventive health services amendment would take a step backwards by substituting the judgment of the independent U.S. Preventive Services Task Force with the judgment of private health insurance companies.

Frankly, it is a point I very much agree with. I don't think we want the judgment of private health insurance companies making these decisions. I think it is appropriate the sponsor of the amendment finish. She is doing a very good job.

Mr. ENZI. I will yield our final minute to the Senator from Wyoming.

The PRESIDING OFFICER. The Senator from Wyoming is recognized.

Mr. BARRASSO. Mr. President, my wife Bobbi was diagnosed with breast cancer by a screening mammogram in her forties. It is that screening mammogram that has saved her life. By the time of the mammogram, the tumor had spread and she has had two operations and two full bouts of chemotherapy. I do not want a government bureaucrat making a decision for the women of America if they should be allowed to have screening mammograms. It saves lives—1 in 1900, for women in their 40s.

The Reid bill empowers bureaucrats to decide what preventive benefits will be allowed for American women. The amendment from the Senator from Maryland does the same—bureaucrats, not the physicians who are doing the treating. That is why I support the amendment of the Senator from Alaska, because that amendment says the Federal Government cannot use recommendations of the U.S. Preventive Services Task Force, recommendations from bureaucrats, to deny care to anyone including seniors on Medicare—anyone in America. That is how this decision should be made, not by government bureaucrats.

I yield the floor.

The PRESIDING OFFICER. The Senator from Maryland is recognized.

Ms. MIKULSKI. Mr. President, how much time is there on our side?

The PRESIDING OFFICER. The Senator has 3 minutes.

Ms. MIKULSKI. Mr. President, I yield myself 3 minutes.

As we get ready to conclude the debate on both the Mikulski as in BARBARA MIKULSKI and Murkowski as in LISA MURKOWSKI amendments, I want to first say a word about the Senator from Alaska. We have worked together on the Health, Education, Labor and Pensions Committee. We have worked together as women of the Senate, to provide access to women's health services. Not too long ago, when I had my awful fall, she gave me much wisdom and counsel and practical tips because she herself had broken her ankle. To us, when you say to Senator LISA or Senator BARB, ''Break a leg,'' it has a whole different meaning. I again thank her for all her work. I have great respect for her. I look forward to our continued working together.

But I do sincerely disagree with her amendment because what her amendment does is, it guarantees, really, only information. It does not guarantee universal access to preventive and screening services.

It also does not remove the cost barriers by eliminating the high deductibles for the copayments when you go to get a preventative or screening service. It tells insurance companies to give information on recommended preventative care. That is a good thing, but it is a threshold thing. You need to have universal access to the service.

In addition, we do not mandate that you have the service; we mandate that you have access to the service. The decision as to whether you should get it will be a private one, unique to you. We leave it to personalized medicine. So in the poignant case of the wife of the Senator from Wyoming, it would have been up to the doctor, the physician, to get her the service she needed.

It is not only I or one side of the aisle that is opposing the Murkowski amendment. The American Cancer Society, the American Heart Association, and the American academy of GYN services oppose it.

My amendment is a superior amendment because it guarantees universal access to preventative and screening services. It also eliminates one of the major barriers to accessing care by getting rid of high payments and deductibles. It doesn't say you will have a mammogram at 40 because, again, we are substituting ourselves for the task force; it says you will have universal access to that mammogram if you and your doctor decide it is medically necessary or medically appropriate.

Vote for Mikulski. Don't vote for Murkowski. And please, on this one, get it straight.

The PRESIDING OFFICER. Under the previous order, the question is on agreeing to amendment No. 2791 offered by the Senator from Maryland, Ms. MIKULSKI, as amended.

Ms. MIKULSKI. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The clerk will call the roll.

The assistant legislative clerk called the roll.

The result was announced—yeas 61, nays 39, as follows:

[Rollcall Vote No. 355 Leg.]

YEAS—61

Akaka	Collins	Kirk
Baucus	Conrad	Klobuchar
Bayh	Dodd	Kohl
Begich	Dorgan	Landrieu
Bennet	Durbin	Lautenberg
Bingaman	Feinstein	Leahy
Boxer	Franken	Levin
Brown	Gillibrand	Lieberman
Burris	Hagan	Lincoln
Byrd	Harkin	McCaskill
Cantwell	Inouye	Menendez
Cardin	Johnson	Merkley
Carper	Kaufman	Mikulski
Casey	Kerry	Murray
Nelson (FL)	Shaheen	Vitter
Pryor	Snowe	Warner
Reed	Specter	Webb
Reid	Stabenow	Whitehouse
Rockefeller	Tester	Wyden
Sanders	Udall (CO)	
Schumer	Udall (NM)	

NAYS—39

Alexander	DeMint	LeMieux
Barrasso	Ensign	Lugar
Bennett	Enzi	McCain
Bond	Feingold	McConnell
Brownback	Graham	Murkowski
Bunning	Grassley	Nelson (NE)
Burr	Gregg	Risch
Chambliss	Hatch	Roberts
Coburn	Hutchison	Sessions
Cochran	Inhofe	Shelby
Corker	Isakson	Thune
Cornyn	Johanns	Voinovich
Crapo	Kyl	Wicker

The PRESIDING OFFICER (Mr. BURRIS). On this vote, the yeas are 61, the nays are 39. Under the previous order requiring 60 votes for the adoption of this amendment, amendment No. 2791, as amended, is agreed to. Under the previous order, the motion to reconsider is considered made and laid upon the table.

AMENDMENT NO. 2836

Under the previous order, there will now be 2 minutes of debate, equally divided, prior to a vote in relation to amendment No. 2836, offered by the Senator from Alaska, Ms. MURKOWSKI.

The Senator from Maryland.

Ms. MIKULSKI. Mr. President, I rise in opposition to the Lisa Murkowski amendment. Though well-intentioned, it does not guarantee universal access to preventive and screening services for women. It does not remove the cost barriers of high payments and codeductibles. It is opposed by the American Cancer Society and the American Heart Association. It primarily provides information on those matters.

We salute her intention, but we think her amendment is too limited, and, to quote the American Heart Association, it would be an actual ''step backwards'' in the area of making preventive services available, particularly not only in the matter of cancer but in heart and vascular disease—the emerging No. 1 killer for women.

I urge defeat of the Murkowski amendment.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Alaska.

Ms. MURKOWSKI. Mr. President, the purpose of this amendment is to ensure we do not have government entities that are making those decisions we as individuals working with our doctors feel is best.

The intent behind this amendment is to ensure that those medical professional organizations, whether it is the American Society of Clinical Oncology or the American College of Surgeons or the American College of Radiation Oncology or the American Society of Obstetricians and Gynecologists—those who are in the practice, those who are making the recommendations—these are the individuals we want to know are being consulted, not some entity that has been created by those of us in the government or by some administration, by some Secretary.

So what we propose with this amendment is an insurance offering, if you will. You will know fully what is part of your plan. It is you and your doctor making these decisions.

I urge a ''yes'' vote on this amendment.

Mr. ENSIGN. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There appears to be.

The question is on agreeing to the Murkowski amendment.

The clerk will call the roll.

The bill clerk proceeded to call the roll.

The result was announced—yeas 41, nays 59, as follows:

[Rollcall Vote No. 356 Leg.]

YEAS—41

Alexander	DeMint	McCain
Barrasso	Ensign	McConnell
Bennett	Enzi	Murkowski
Bond	Graham	Nelson (NE)
Brownback	Grassley	Risch
Bunning	Gregg	Roberts
Burr	Hatch	Sessions
Chambliss	Hutchison	Shelby
Coburn	Inhofe	Snowe
Cochran	Isakson	Thune
Collins	Johanns	Vitter
Corker	Kyl	Voinovich
Cornyn	LeMieux	Wicker
Crapo	Lugar	

NAYS—59

Akaka	Franken	Mikulski
Baucus	Gillibrand	Murray
Bayh	Hagan	Nelson (FL)
Begich	Harkin	Pryor
Bennet	Inouye	Reed
Bingaman	Johnson	Reid
Boxer	Kaufman	Rockefeller
Brown	Kerry	Sanders
Burris	Kirk	Schumer
Byrd	Klobuchar	Shaheen
Cantwell	Kohl	Specter
Cardin	Landrieu	Stabenow
Carper	Lautenberg	Tester
Casey	Leahy	Udall (CO)
Conrad	Levin	Udall (NM)
Dodd	Lieberman	Warner
Dorgan	Lincoln	Webb
Durbin	McCaskill	Whitehouse
Feingold	Menendez	Wyden
Feinstein	Merkley	

The PRESIDING OFFICER. On this vote, the yeas are 41, the nays are 59. Under the previous order, requiring 60 votes for the adoption of amendment No. 2836, the amendment is withdrawn.

Mr. NELSON of Nebraska. Madam President, this afternoon I voted against the amendment offered by my colleague, the senior Senator of Maryland, Ms. MIKULSKI.

I voted against this amendment with regret because I strongly support the underlying goal of furthering preventive care for women, including mammograms, screenings, and family planning. Unfortunately, the amendment did not incorporate language I suggested to specifically clarify that abortion would not be covered as a future preventive care service. I appreciate the assurances from Senator MIKULSKI in a colloquy on the floor that abortion would not be covered as a preventive service, but words do not supersede the language in the legislative text. I do

look forward to ways in which Congress can further preventive care services for women.

The PRESIDING OFFICER. The Senator from Colorado is recognized.

AMENDMENT NO. 2826 TO AMENDMENT NO. 2786

Mr. BENNET. Mr. President, I have an amendment No. 2826 at the desk. I would like to call it up at this time.

The PRESIDING OFFICER. The clerk will report.

The assistant bill clerk read as follows:

The Senator from Colorado [Mr. BENNET], for himself, Mr. HARKIN, Mr. DODD, Mr. BROWN, Mr. DURBIN, Mrs. LINCOLN, Mr. WYDEN, Mr. BEGICH, Mr. BAYH, and Mrs. SHAHEEN, proposes an amendment numbered 2826 to amendment No. 2786.

Mr. BENNET. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To protect and improve guaranteed Medicare benefits)

On page 1134, between lines 3 and 4, insert the following:

Subtitle G—Protecting and Improving Guaranteed Medicare Benefits

SEC. 3601. PROTECTING AND IMPROVING GUARANTEED MEDICARE BENEFITS.

(a) PROTECTING GUARANTEED MEDICARE BENEFITS.—Nothing in the provisions of, or amendments made by, this Act shall result in a reduction of guaranteed benefits under title XVIII of the Social Security Act.

(b) ENSURING THAT MEDICARE SAVINGS BENEFIT THE MEDICARE PROGRAM AND MEDICARE BENEFICIARIES.—Savings generated for the Medicare program under title XVIII of the Social Security Act under the provisions of, and amendments made by, this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.

Mr. BENNET. Mr. President, I was paying very close attention to the floor debate over the last few days, and at times I am beginning to wonder what bill it is we are debating. Only in Washington could an effort to extend the life of the Medicare trust fund be viewed or distorted somehow as being unfair or bad for seniors.

We know—and it is in print in the CBO report—this bill doesn't take away any senior's guaranteed Medicare benefits. We know the bill extends Medicare solvency for 5 additional years. How does it do that? It does it in a way that is different from the way government usually does business, which is either adding or cutting from a program. It changes the way we deliver medicine in this country, and it does it in a way that protects senior benefits, and it extends the life of Medicare.

The attacks on this bill and my amendment have nothing to do with those facts. The sad part is that there are ideas on every side of this debate that are worth considering. We should be debating those ideas rather than claiming something that is just not true about the bill.

These Washington tactics of trying to shift health care reform back to some committee to languish is exactly why nothing ever gets done around here. The almost unbelievable part of this is that the opponents of my amendment say the health care bill hurts seniors. Yet the bill and our amendment is being supported by the AARP, the Alliance for Retired Americans, Center for Medicare Rights, and the National Committee to Preserve Social Security and Medicare.

What are the opponents of my amendment actually saying—that AARP and other senior advocates don't know what they are doing? They know what they are doing, and they also know what is in the bill. The AARP has seniors' best interests in mind, and they want what is best for Medicare in the long run. This bill makes tremendous strides to a more solvent, more stable Medicare Program for years to come.

Unfortunately, in the hopes of eventually trying to kill the bill, there are people who are making claims that are frightening our seniors—meant to frighten them—here and also in Colorado, where people have been calling on their phones convinced that somehow I want to cut their benefits. Nothing could be further from the truth. I believe strongly in the sacred trust we have created with our seniors. That is why I introduced this amendment. Seniors are looking for simple clarity, and health care reform can help their lives.

This amendment says, in the clearest and most unambiguous of terms, as directly as we can say it, that nothing in this bill will cut guaranteed Medicare benefits. All guaranteed Medicare benefits stay intact for every senior in Colorado and all across the country. Seniors will still have access to hospital stays, to doctors, home health care, nursing homes, and prescription drugs.

The second part of the amendment goes further and says clearly and directly to seniors that we will use this bill to further protect and strengthen Medicare. We will extend the life of the Medicare trust fund. We will lower premiums or cost share, increase Medicare benefits, and improve access to providers. You don't need to believe me. Look at the CBO. These improvements will be paid for with money saved in Medicare under this bill.

What is so regrettable about the debate, and so tragic, is, if we don't actually get this done, Medicare would be bankrupt in just 7 years—in 2017. In the Senate bill we are now considering, we extend the trust fund's solvency by 5 years. We lower premiums for seniors by $30 billion over 10 years. That is real money back in the pockets of our seniors. We eliminate copays that seniors now have to pay for preventive care. That means when seniors go to the doctor for a colonoscopy, they would not have to make the copay like they have to under current law. When they go to get a mammogram, the same is true. We know preventive care like that saves lives and also money.

Most seniors live on a fixed income. Free preventive care is the best way to encourage seniors to seek important medical precautions. More preventive care is proven to save lives and lower health care costs.

Mr. President, health care reform will cut the cost of brand-name prescription drugs in half for those who are stuck in the gap of coverage between initial and catastrophic coverage. We eliminate the 20-percent cut physicians would otherwise see next year, making sure seniors can continue to see their own doctor.

Opponents of health care reform don't have a plan to protect seniors and strengthen the Medicare Program. I have heard more criticism about the number of pages in the bill than I have heard about a responsible alternative that would extend the life of Medicare and make the other benefits that are in this bill.

I wanted to come to the floor with a simple and straightforward message to seniors: We will protect Medicare. This bill does. We will make sure nobody touches your guaranteed benefits. This bill does. We will make sure Medicare is around for future generations. This bill gets us started in that direction. That is why I have introduced this amendment and why I support health care reform.

Everything I have said today is entirely consistent with the findings of the CBO, the nonpartisan organization that advises this Chamber. This legislation makes explicit the commitment that all of us share to the seniors across the United States of America. It is my hope that once this amendment passes, we can get beyond the debate we have had over the last 72 hours and get on to the substantive aspects of the bill.

I urge support for my amendment. I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio is recognized.

Mr. VOINOVICH. Mr. President, over the past several months I have come to the floor on a couple of occasions to remind my colleagues and the American people about the unsustainable fiscal crisis confronting this country.

Our national debt has exceeded $12 trillion for the first time in history. In fact from 2008 to 2009 alone, the Federal debt will increase 22 percent, boosting the country's debt-to-income ratio—or national debt as a percentage of GDP—from 70 percent last year to 86 percent this year. We have not seen this kind of debt to GDP ratio since the Second World War 65 years ago.

The American people know that this is unsustainable, but my Senate colleagues from on the other side of the aisle continue to ignore this reality. I pledged that I would continue to cry ''the emperor has no clothes'' until we did something to address this crisis.

I should explain. Most people know the story, ''The Emperor's New Clothes,'' by Hans Christian Anderson.

In the tale, an emperor goes about the land wearing a nonexistent suit sold to him by a new tailor who convinced the monarch the suit is made of the finest silks. The tailors—two swindlers—tell the emperor that the threads of his robes will be so fine that they will look invisible to those dimwitted, or unfit for their position. The emperor and his ministers, themselves unable to see the clothing, lavish the tailor with praise for the suit, because they do not want to appear dimwitted or incompetent.

Word spread across the kingdom of the emperor's beautiful new robes. To show off the extraordinary suit, a parade was formed. People lined the streets to see the emperor show off his new clothes. In this case, the health care reform bill before the Senate.

Again, afraid to appear stupid or unfit, everyone pretends to see the suit. It is only when a child cries out ''the emperor wears no clothes'' does the crowd acknowledge that the emperor is, in fact, naked.

Like the little boy crying out, those of us on this side of the aisle are pointing out this bill is fiscally not responsible.

Yet, while not addressing our current health care challenges, the so-called health care reform bill we are debating also creates new programs at a time when we aren't paying for the one we already have, and it adds $2.5 trillion to what we are already spending.

I learned as a mayor and as a Governor, if you cannot afford what you are doing, how can you take on new responsibilities?

We could be using this opportunity to fix our health care system by finally working to lower health care costs and pass those savings on to citizens who are already overburdened by an expensive health care system.

Yet instead of commonsense incremental reforms that increase access to affordable, quality health care, reduce the costs of health care for all Americans, and lower our national health care spending, we have this bill before us.

Unfortunately, the bill violates the medical principle, first, do no harm. Instead, it is more of the same—more spending and more taxes—on an already struggling economy, this at a time when we are currently witnessing the worst recession this country has experienced since the Great Depression.

The legislation we are considering when fully implemented, as I pointed out, spends $2.5 trillion to restructure our health care system. Yet it fails to rein in the cost of health spending in the next decade. According to the Congressional Budget Office, the Federal Government's commitment to health care; that is, the cost of health care paid for by the Federal Government, would actually increase. In other words, we are adding more on to this extraordinary debt we have—unfunded mandates we have—in terms of Medicare.

The bill's proponents will tell you it is paid for. But as David Broder points out in his November 22 Washington Post editorial:

> While CBO said that both the House-passed bill and the one Reid has drafted meet Obama's test by being budget neutral, every expert I have talked to says the public has it right. These bills, as they stand, are budget-busters.

And that is what many people are hearing right now from their constituents, particularly many of those individuals who are taking advantage of the Medicare Advantage Program.

Furthermore, as former CBO Director Douglas Holtz-Eakin pointed out in the Wall Street Journal, this bill uses ''every budget gimmick and trick in the books.''

What are these gimmicks? Most troubling to me and what my colleagues on the floor have been discussing for the last few days is what the bill does to the Medicare Program.

I think we need to be honest with the American people. The Medicare Program is already on shaky footing. Despite $37 trillion in unfunded—unfunded—future Medicare costs and the prediction that the Medicare trust fund is expected to be insolvent by 2017, this bill calls for $465 billion in cuts to Medicare, not to fix the program but, as I said, to create new programs.

For example, this health care bill fails to acknowledge the $250 billion that is necessary to reform the Medicare physician payment formula to ensure that our Nation's seniors will be able to see the doctor of their choice in the future. I have heard it firsthand from family and friends that in some places in Ohio, Medicare beneficiaries already face delays for physician services.

Right in my hometown, I have had doctors tell me: GEORGE, if I have somebody before they are Medicare eligible and they go on Medicare, I will take care of them. I am not taking anymore new Medicare patients because of the reimbursement system. I heard the same thing in terms of Medicaid.

We have a problem out there. Sadly, my friends on the other side of the aisle do not want to be honest with the American people and include the cost of the physician payment fix in the bill. It should be there. Let's be honest about it. Let's be transparent. It is another example, I think, of the smoke and mirrors and budget gimmicks and tricks that former CBO Director Douglas Holtz-Eakin mentioned.

Like I said, we must fix our health care system to help millions of Americans who find themselves without insurance and those struggling to pay their health insurance premiums. We must increase competition in the private market, make it easier for small businesses and individuals to purchase insurance and reform our medical liability system. I call this malpractice lawsuit abuse reform. We should have done that a long time ago. But the fact is that the trial lawyers do not want that to happen. So we are doing nothing about a problem that is causing physicians to give unnecessary tests that are driving up the cost of health care in this country.

Most important, we need to focus our efforts on jobs, jobs, jobs, jobs, jobs because one of the best things we can do to increase health care coverage is to help businesses start to hire again. I need a job. One of the reasons I need a job is when I have a job, in most instances, I have some form of health care. We have a lot of people who are being dropped off. We need more jobs. We should be concentrating on that if we want to up the number of people who can get health care.

To repeat, we do not need to create another set of government programs that spends an additional $2.5 trillion to build a new entitlement system when we cannot afford the one we have now. That is the biggest thing with me. If you cannot afford what you have, how can you take on more? When we do that, we are being fiscally irresponsible. We should deal with what we have. It is amazing to me. If you look around the country, States are cutting their expenses and they are raising taxes. And what are we doing in Washington? We are taking on more expensive programs we cannot afford. That is what I think is troublesome to me as a debt hawk.

We need to understand what we are doing. The American people are paying attention and they know that the emperor has no clothes when it comes to doing something about our unsustainable fiscal crisis.

We are losing our credibility and our credit worldwide. They know it is immoral to be putting this debt on the backs of our children and grandchildren. I believe this health care bill does that exactly. It exacerbates our current fiscal situation.

There are lots of good things out there, a lot of good things we all would like to do. But just like a family, if you cannot afford what you are doing now, how can you afford to take on more responsibility in terms of debt?

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. REED. Mr. President, I think it is important to focus on the fiscal difficulties we have today, but I think it is also important to recognize the probable causes of these huge deficits: two wars, unfunded, no attempt to fund them, spent simply by running up the deficit; tax cuts, which were unfunded and which did not ultimately generate the kind of sustained economic growth and job growth that their supporters advertised, and then the Medicare Part D program, an entitlement program which was also completely unpaid for.

Today we have people talking about entitlement reform, how that is a key aspect of health reform. But so many of my colleagues on the Republican side supported President Bush when he

proposed the Medicare Part D program, a worthy program in concept, but in the context of not paying for it, it is a concept that is costing us greatly today.

Additionally, it is particularly ironic at this moment, because we are considering a McCain motion that would report this health care bill back to the committee with the instructions to restore $400 billion in spending, roughly, over 10 years. I cannot think of anything more contrary to the notion of entitlement reform.

What we have tried to do in this bill is to restructure Medicare so that it will continue providing quality health care, but also recognize the high costs we are facing going forward and the general economic climate we face today. Again, let me remind you, in January 2001, the unemployment rate was about 4.6 percent. When President Obama took office, it was double that and growing and continuing to grow.

We have seen some effects to limit this growth, but it is still a critical issue. Again, this reform package is designed not only to deal with the quality of health care, accessibility to health care, and affordability of health care, but it is designed to, over the long term, begin to rein in costs that are absolutely out of control.

Those suffering the most from this course are the American people and, in some respects, small business men and women. Their health care costs are going up faster than any other costs, and in many instances faster than wages, and it is unsustainable.

If in my State of Rhode Island we do not take effective action, we will see within several years premiums reaching $24,000 to $30,000 a year for a family of four. We cannot sustain that.

If someone is interested in taking the very difficult step of entitlement reform, they would reject the McCain motion. But there are other reasons to reject the amendment, as well. First, the funding that has been eliminated from the current health care system and the system going forward, has been eliminated because it does not improve care. This is particularly true in Medicare Advantage.

This was a program that was developed and sold essentially to the American people as cost containment for Medicare. This was one of the proposals that would rein in out-of-control health care costs by giving insurance companies the ability to manage more effectively.

Of course, what we have seen is a significant increase in payments to Medicare Advantage payments over traditional Medicare. Of course, these insurance companies can manage health care very well as long as they are receiving very significant premium payments from beneficiaries. But, those premiums do not essentially go to better health care. It certainly goes, however, to better profits for the insurance companies.

Indeed, with Medicare Advantage there is a rebate given to each insurance company. This is not the case with traditional Medicare. The rebate was designed essentially to provide, again, lower cost access to health care benefits for the consumers of Medicare Advantage.

The GAO found that 19 percent of Medicare Advantage beneficiaries actually pay more than traditional Medicare for home health care and 16 percent pay more for inpatient services. Here is the irony. We are paying the insurance companies more, but the beneficiaries of Medicare Advantage are, indeed, are also paying more. So there is no cost savings in this regard, in this program at least.

The other point, which is I think critical and I alluded to, is that for the same services you receive in Medicare Advantage, there is, on average, a 14-percent increase overall for those similar services in traditional Medicare.

We have to, I think, take tough steps to eliminate these over-payments, but steps that will enhance the quality of care for seniors, and that is what is being done in this bill. While some of these resources are being used to help redesign a system for all Americans, there will also be significant improvements for seniors, for care that is more effective and efficient, and less costly.

Let me suggest something else. We are all paying right now for the cost of uninsured Americans. It has been estimated that every private insurance plan in this country is paying—every individual payer, businesses or individual—about $1,000 a year for uncompensated care. That is the cost hospitals shift from their uncompensated care on to the insurance providers, the carriers, and that is translated into higher premiums for all Americans.

Under this legislation, the hospitals will now see patients presenting themselves with an insurance card. Mr. President, over 94 percent of Americans, it has been estimated, will be covered under our proposal. So instead of showing up for free care, they will be under an insurance plan. The hospitals will benefit. Medicare, Medicaid, and the whole health care system will benefit.

Again, this is one of the changes that would be reversed by the McCain motion.

Also, we have taken steps so that hospitals will be much more effective in managing their patient flow. Readmissions will hopefully be reduced by some of the provisions in this legislation.

There are many things we should do and will do, but I believe we can successfully balance expanding our coverage system, protecting quality of care, but also recognizing, as has been suggested, the fiscal implications not just for the moment but going forward. I suggest if someone is serious about entitlement control, serious about the fiscal implications of this legislation or any other legislation, they will not simply order the committee to restore these cuts. They would do something much more proactive and, indeed, support what I believe are sensible, sound proposals to provide quality, to ensure that over the long run, Medicare is more solvent.

In fact—the final point—the legislation before us would extend the life of Medicare, the solvency of Medicare over at least 5 years. So for those people who say we are trying to end Medicare, their solution is simply to let it go bankrupt apparently in 2017 or to simply ignore it and let it find its own fate.

We can do better. I urge rejection of the McCain motion. I yield the floor.

The PRESIDING OFFICER (Mr. UDALL of New Mexico). The Senator from Wyoming is recognized.

Mr. BARRASSO. Mr. President, I come to the floor also to talk about Medicare and what I see to be significant cuts in the Medicare Program. I practiced medicine in Wyoming for 25 years, taking care of families from across the State and many of these wonderful folks who are on Medicare. They depend on Medicare for their health care. They depend on Medicare. Patients depend on it, the hospitals depend upon it, the physicians, the nursing homes, the home health care agencies—all of them depend on Medicare for their health care.

I listened to my close friends from across the aisle come to the floor as well, and they seem to be trying to convince the American public that the 2,074-page bill which weighs over 20 pounds actually does not cut Medicare. I heard the chairman of the Finance Committee talk about it on the floor; I have heard it from the majority leader.

The health care reform plan we are looking at on this floor cuts $464 billion from Medicare, and I have a list of all the Medicare cuts in this bill, page after page, column after column. When you add them all up, it cuts $135 billion from our hospitals—from our hospitals—that are providing the care. We have heard about some of the cost shifting from the Senator from Rhode Island. Cost shifting occurs. Medicare is one of the biggest deadbeats when it comes to paying for hospital services, and it is why hospitals end up shifting more costs to people who have health insurance, and why, for those people, their premiums will go up if this bill becomes law. So $135 billion cut from hospitals.

The bill cuts $120 billion from a program called Medicare Advantage. There are 11 million Americans in this country who are on Medicare Advantage. They know who they are. They know it is a program that has worked well for them. People ask me what the difference is. Why would somebody want to be on a program called Medicare Advantage? Well, there is an advantage to those seniors who depend upon Medicare for their health care if they are on Medicare Advantage. The No. 1 advantage is, it actually helps coordinate care.

We know one of the best ways to help people keep down the cost of their medical care is to find problems early and to get early treatment. So find the problem and treat it before it gets too bad. Well, Medicare Advantage does both preventive care as well as coordinated care. One of the big problems with Medicare is, it will pay a lot for doing something to someone, but it will not pay much for helping someone stay healthy. But now all of a sudden we are going to cut $120 billion from Medicare Advantage, which actually works on prevention and on coordinated care.

Then there is $42 billion from home health care agencies that will be cut. Those are the folks who come into someone's home and help them stay out of the hospital. The advantage of home health care is to allow people to get care at home and not need to be in the hospital, but suddenly we are looking at $42 billion in cuts on Medicare for home health care agencies.

Then let's take a look at nursing homes: $15 billion in cuts for nursing homes—those facilities taking care of people on Medicare—which, to me, means they are actually cutting it from the people who depend on Medicare for their nursing home needs.

As an orthopedic surgeon, I have taken care of many people, such as a grandmother who breaks her hip. She doesn't need to go into a nursing home permanently, but what she needs to do is to go there for a short period of time for rehabilitation, where she can get better and get stronger. She is not ready to go home, and she does not need to stay in a hospital, but she needs to be in a nursing home for a period of time to get rehabilitated and then to get ready to go home and go back to an independent life. There is a gap in time, and nursing homes help with that. They are wonderful as a way to give somebody an opportunity to gain their strength. In our country, such as it is now, so many grandparents are living in communities where, perhaps, their children or grandchildren are no longer living or they can't go and live with a son or daughter, but they need additional help and so they go to a nursing home.

So for that patient who has broken a hip—the type of patient I have taken care of in the hospital—this bill is going to end up cutting from the hospital $135 billion from Medicare for that patient. It will end up cutting nursing homes by $15 billion, for patients who rely on nursing homes as they recover from their hip surgery. Then once they get home and get ready for an independent life, a lot of times they can benefit from home health care—someone coming into the home and checking on them, giving them medications, making sure they are doing all right, checking their wound, and a number of different things—this bill will cut $42 billion from home health care agencies; again, cutting the services to people who depend upon those services for their health care needs.

Then there is an $8 billion cut from hospice providers, people who take care of our patients—my patients—in the final stages of their life. At a time in their life when their body may be riddled with cancer or they just need a place to go and be treated with respect and to be cared for, we are cutting $8 billion in this bill from the hospice providers—people who are there and helping people in the final stages of their life.

When I look at this, I say: How in the world can my colleagues on the other side say they are not cutting Medicare for our seniors? I read through the bill and there is $135 billion from hospitals, $120 billion from Medicare Advantage, $40 billion from home health care agencies, almost $15 billion from nursing homes, and $8 billion from hospice providers, for a total of $464 billion for this country's seniors. I don't think we should pass this bill. Of course, there is another $500 billion in taxes. It is a huge and hugely expensive bill.

To me, this is absolutely nothing but robbing our folks who are on Medicare to start a whole new government program. I am worried seniors all around the country are going to have less access to doctors, especially in rural and in frontier States, such as Wyoming. I am concerned they are going to see community hospitals and home health care agencies and nursing homes—skilled nursing facilities—struggling to keep their doors open.

It is time for this Congress, for this Senate to listen to America's seniors. Let's listen to the administration's own chief actuary. Richard Foster, the chief actuary for the Centers for Medicare and Medicaid Services, said if these Medicare cuts take effect, then many providers ''could find it difficult to remain profitable and might end their participation in the program.'' They may say: I don't want anything else to do with Medicare. I am closing my doors to Medicare patients.

We cannot have that in this country, but I believe that is what this bill does. Even the nonpartisan Congressional Budget Office said these Medicare cuts could ''reduce access to care or diminish the quality of care.'' Is that what this Senate wants, to reduce access to care or diminish the quality of care?

How many experts does it take to convince the majority party that cutting Medicare to pay for a brandnew government program is irresponsible? We all agree Medicare is going broke. The trust fund will run out of money in the year 2017. It has more than $37 trillion in unfunded liabilities. The Presiding Officer knows that in his State, as well as in mine, Medicare's physician payment formula, which calls for doctors to face a more than 40-percent cut over the next 10 years, is a system that is broken. The Reid bill does nothing to fix this problem. Instead, it takes $½ trillion from Medicare to create a brandnew entitlement program. It punishes a group of people in order to benefit another. To me, that is not reform. It will only make the system worse.

That is why I support the motion we will be voting on today, the McCain motion. It says we are not going to finance a new government program on the backs of our Medicare patients, on the people who depend upon Medicare for their health care. It instructs the Finance Committee to write a bill that doesn't cut hospitals, that doesn't cut home health care, that doesn't cut Medicare Advantage, and that doesn't cut hospice for our seniors who depend upon those services. A vote for the McCain motion gives us a chance to get this right.

I do want health care reform. I just don't want this bill. This is the wrong prescription for our country. I don't believe we have to take the money out of Medicare and then spend it on a brandnew entitlement program. I go home to Wyoming every weekend—and I know other Members go home and listen to their constituents—and what I hear from the people in Wyoming is: Don't cut my Medicare. Don't raise my taxes. Don't make things worse for me in this economy. I certainly can't afford it. The people of Wyoming want practical, commonsense health care reform; reform that drives down the cost of medical care, improves access to providers and creates more choices.

It is clear this bill has a very different plan in mind. It is not too late to work together for meaningful reform. We do not have to dismantle the current health care system and build it up in the image of big government and then try to say this is reform. The American people are telling us what kind of changes they want, and that is why I will be voting for the McCain motion.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I wonder if the Senator from Wyoming would be available to answer a question.

Mr. BARRASSO. I will, Mr. President.

Mr. BAUCUS. I am thankful to my good friend and neighbor to my State.

Is it true the CBO letters say the Senate bill will extend the life—extend the solvency of the Medicare trust fund? Is that true?

Mr. BARRASSO. I don't have that letter with me, but everything I look at says this will gut Medicare, make it go broke sooner, and it will be bad for seniors.

Mr. BAUCUS. I don't have the letter in front of me, but in all deference and respect to my good friend from Wyoming, the CBO says the exact opposite. It is the conclusion of the Congressional Budget Office that this legislation will help seniors by extending the solvency of the Medicare trust fund by, I guess, 4 to 5 years. That is black and white. If I had the letter in front of me, I could read it to him, but that is a

fact. This legislation will extend the solvency of the Medicare trust fund by another 5 years.

So instead of being insolvent in the year 2017, under this legislation, that is extended to the year 2022. That is a fact. At least the fact is that is what CBO concludes in their letter. That is a fact.

Second, as a caring physician, does the Senator think that we as a country should try to find a way to provide health insurance for so many Americans—some of them lower income—who don't have health insurance in our country? Because, after all, we are the only industrialized country in the world that doesn't find a way to make sure its citizens have health insurance.

As a physician who sees patients, many of whom can't pay their bills and defer medical treatment because they do not have health insurance, I am wondering if the Senator believes this country should try to find a way where its citizens have health insurance.

Mr. BARRASSO. The Senator absolutely believes we need to find a way to make sure all the citizens of this country have insurance, and there are ways to do it: allowing people to buy insurance across State lines. That doesn't take a 2,000-page bill. There are ways to do it to help get down the cost of care that give individuals incentives to buy their own insurance, giving tax breaks to those individuals. We could do things with tort reform, such as the loser pays rule. We could allow small groups to join together to have a better ability to bargain and get the cost of insurance down.

So this Senator absolutely believes we need to find a way to get everyone insured. There are people who need help who don't have help, and we need to find a way to do that, but it is not this 2,000-page bill.

Mr. BAUCUS. I will ask this question, and then I will finish because I know my colleagues want to speak.

One of the basic underpinnings of this legislation is that we should change the way we reimburse providers, moving away from quantity and volume and more toward quality. I am curious—and this is not an antagonistic question. I am just trying to get a physician's point of view because so many doctors I talk to think that although it creates a little uncertainty, probably that is the right thing to do—to move our reimbursing based on quality, coordinated care, and focusing on the patient rather than our current system, which reimburses more on quantity and the number of services provided, et cetera.

Is that something the Senator thinks we should pursue in this country?

Mr. BARRASSO. The current system is broken, Mr. President. The reimbursement system focuses more on doing things than on helping patients stay healthy and get better. Medicare has done a terrible job of that over the years, in terms of giving incentives for people or even for paying for preventive services. They have not done that over the years.

This is an illustration of how the system is broken. It is now December—the end of the year—and it is the busiest time of year for me as a physician in Wyoming because people have met their deductibles—those who have insurance have met their deductibles for the year—and they come into the office and say: Is it now time for my operation? I have to get it done before the 1st of the year because my deductible has been used up, and I want to have my operation so I am not going to have to pay for it.

In this country, we have the incentives all wrong in terms of health care. We do need health care reform.

Mr. BAUCUS. I agree.

Mr. BARRASSO. I don't think this bill is the way to do it, which is a government takeover of the health care system.

Mr. BAUCUS. Mr. President, I have to address that one. My colleagues want to speak, but I think it is worth repeating over and over again: This legislation is designed to retain the uniquely American solution to health care—roughly half public, half private. It is designed to make sure patients can still, as they should, choose their own doctor, any doctor they want—primary care doc, specialist, no gatekeepers and all that stuff. The doctors are totally free and should be free to make their own decisions, after consultation with their patients, as to what procedure makes sense or doesn't make sense.

In addition to that, frankly, more competition with the exchanges. This legislation, frankly, is rooted almost entirely on maintaining the current free market system in health care. There is some insurance market reform, which I think everybody agrees with, which is denying preexisting conditions as a basis for denying coverage, and there is a modest expansion of Medicaid for lower income people who just can't get health care, but otherwise this is legislation which is rooted in the current American system.

We have a good system. It works. This is just designed to make it work a little better by making sure it reimburses, as the Senator from Wyoming wants, based more on quality. He didn't mention this, but I know he agrees, also insurance market reform so those patients who come to him don't have to wait until the end of the year in the future as they have in the past.

But I want to get it very clear, this is no ''government takeover.'' That is a scare tactic. It is not accurate. It is basically maintaining our current system.

I would now like to yield 10 minutes to my good friend from Vermont.

The PRESIDING OFFICER. The Senator from Vermont is recognized.

Mr. SANDERS. I am going to speak on something other than health care. I thank my friend from Montana for yielding.

CONFIRMATION OF FEDERAL RESERVE CHAIRMAN

Mr. SANDERS. Mr. President, what I want to touch upon is my strong belief that Ben Bernanke should not be reappointed for a second term as Chairman of the Federal Reserve. In that regard, I placed a hold on his nomination.

Everyone in this country understands we are in the midst of the worst economic crisis since the Great Depression. We are looking at 17 percent of our people being either unemployed or underemployed. We are looking at average length of unemployment being longer than it has been since World War II. We are looking at a situation where, over the last 8 or 9 years, median household income has declined by over $2,000. We are looking at a situation where, according to USA Today, September 18, 2009:

> The incomes of the young and middle aged, especially men, have fallen off a cliff since 2000, leaving many age groups poorer than they were even in the 1970's.

What we are seeing is a long-term trend resulting in the collapse of the middle class, an increase in poverty, a growing gap between the rich and everybody else. Then, to make a very bad situation worse, as a result of the greed, irresponsibility, and illegal behavior of Wall Street, we are now in a terrible economic decline.

The American people voted overwhelmingly last year for a change in our national policies and for a new direction in the economy. After 8 long years of trickle-down economics that benefited the very wealthy at the expense of the middle class and working families, the people of our country demanded a change that would put the interests of ordinary people ahead of the greed of Wall Street and the wealthy few. What the American people did not bargain for was another 4 years for one of the key architects of the Bush economy, Federal Reserve Chairman Ben Bernanke.

The Chairman of the Federal Reserve—and the Federal Reserve itself—has four main responsibilities. I want the American people to determine whether they believe the Fed has, in fact, succeeded in fulfilling these obligations. Here they are, four main responsibilities:

No. 1, to conduct monetary policy in a way that leads to maximum employment and stable prices. Maximum employment? When you have 17 percent of your people unemployed or underemployed, I do not think the Fed or all of us, any of us, have succeeded in that area.

No. 2, to maintain the safety and soundness of financial institutions. Obviously, that has not been the case either.

No. 3, to contain systemic risk in financial markets.

No. 4, to protect consumers against deceptive and unfair financial products.

Not since the Great Depression has the financial system been as unsafe,

unsound, and unstable as it has been during Mr. Bernanke's tenure. More than 120 banks have failed since he has been Chairman, and the list of troubled banks has grown from 50 to over 416.

Mr. Bernanke has failed to prevent banks from issuing deceptive and unfair financial products to consumers. Under his leadership, mortgage lenders were allowed to issue predatory loans that they knew consumers would be unable to repay. This risky practice was allowed to continue long after the FBI warned, in 2004, of an epidemic in mortgage fraud.

Here is what the bottom line is. The bottom line is that the key responsibility of the Fed is to maintain the safety and soundness of our financial institutions, and they failed. They failed. As a result of the greed and speculation on Wall Street—which the Fed should have been observing, which the Fed should have acted against, which the Fed should have warned the American people and the Congress about—they did nothing and our financial system went over the edge.

Then, after not doing their jobs as a watchdog, not fulfilling their obligation to protect the safety and soundness of our financial system, the financial collapse occurred, and what happened? What the Fed did is provide not only—not only did Congress put $700-plus billion into the bailout, the Fed provided several trillion dollars of zero-interest loans to large financial institutions. When I asked Chairman Bernanke which financial institutions received these zero-interest loans, the answer was: I am not going to tell you. Not going to tell you.

The reason Congress, against my vote, bailed out Wall Street is they were too big to fail. Large financial institutions were too big to fail. Since the collapse, three out of the four largest financial institutions have become even larger. So the systemic danger for our economy is even greater today than it was before the bailout.

The American people want a new Wall Street. They want a Wall Street which begins to respond to the needs of small business, so we can begin to create jobs, not just to Wall Street's outrageous executive compensation.

Let me suggest some of the things I think a Fed Chairman should be doing, things Mr. Bernanke is not.

No. 1, today, bailed out financial institutions are charging consumers 25 or 30 percent interest rates on their credit cards. The Fed has the power to stop that, to put a cap on interest rates. That is what they should be doing.

The Fed has the power to demand that bailed-out institutions provide loans at low interest rates to small and medium-sized businesses so we can begin to create the kinds of jobs that are desperately needed in this country. That is not what Mr. Bernanke has done.

The Fed has the power now to do what is taking place in the United Kingdom, something that many economists are demanding, and that is to start breaking up these large financial institutions which are too big to fail. In my view, if an institution is too big to fail, it is too big to exist. We have to start breaking them up, not allow them to get even larger. The Fed has chosen not to do that.

We need transparency at the Fed. I am the author of a GAO audit of the Fed, which now has 30 cosponsors, which I hope we will pass. But at the very least, if the taxpayers of this country are putting at risk trillions of dollars being lent out to large financial institutions, we have a right to know which institutions are receiving that money and under what terms.

Let me conclude by saying this: This country is in the midst of a horrendous economic crisis. Millions of families all over this country are at their wit's end. They are suffering. They are trying to figure out how they are going to keep warm this winter, how they are going to pay their bills. The time is now for a new Fed, for a new direction on Wall Street, for a Wall Street which is helping our productive economy create decent-paying jobs, not a Wall Street based on greed, only for themselves, whose goal in life is to make as much money as possible for their CEOs.

We need a new Fed, we need a new Wall Street, and we surely need a new Chairman of the Fed. My hope is that President Obama will give us a new nominee and not Mr. Bernanke.

I yield the floor.

The PRESIDING OFFICER. Who yields time? The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask how much time is remaining on each side?

The PRESIDING OFFICER. On the majority side, 9 minutes 20 seconds; on the minority side, 23 minutes 10 seconds.

Mr. BAUCUS. Mr. President, I yield 9 minutes—how many seconds?

The PRESIDING OFFICER. Now 9 minutes 11 seconds.

Mr. BAUCUS. I yield 9 minutes 11 seconds to the Senator from Iowa.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. HARKIN. I am deeply saddened that my Republican colleagues have, now we see very clearly, resorted to fear tactics in their desperate attempt to preserve a dysfunctional, costly, status quo medical system that we have in this country today. Republicans, in their attempt to strike fear in seniors across the country, are trying to convince the people that they have changed from the party that has always opposed Medicare to now being Medicare's staunchest defenders. But we all know, if it were up to our friends on the other side of the aisle, there would be no Medicare. They fought its very creation. Don't take my word for it, take one of their standard-bearers who ran for President. Senator Bob Dole, who was here when we created Medicare, Senator Dole, a friend of mine—I have a good deal of admiration for Senator Dole—said, ''I was there, fighting the fight, voting against Medicare—one of twelve—because we knew it wouldn't work in 1965.'' He said that in 1995 when he was running for President. He was proud of the fact that he and Republicans had opposed the establishment of the Medicare system.

You might say: That was then, what about recently? Here is the former Speaker of the House, Newt Gingrich. He said, ''We believe it's going to wither on the vine,'' speaking of Medicare.

Now my friends on the other side of the aisle—listening to them, you would think they were the biggest supporters of Medicare forever, when they opposed it from its very beginning.

Now we hear all the stuff about Medicare Advantage. If, in fact, we are going to be cutting a little bit out of Medicare Advantage, they would like to tell you that somehow this is going to ruin Medicare. If that were true, why would the National Committee to Preserve Social Security and Medicare, AARP, the alliance for retired Americans, groups that represent tens of millions of seniors—why would they stand with us in support of our bill and not with the Republicans, who want to gut the very provisions we have in there that will strengthen and preserve Medicare?

Do people really believe our Republican colleagues care more about seniors than these groups that actually represent seniors?

The truth is, when we talk about Medicare Advantage, we are talking about private insurance companies who promised that through competition they were going to deliver better quality health care to seniors at a lower cost. It all sounded good. But what has happened since Medicare Advantage has come in? The reality is, Medicare is now paying on average 14 percent more to these private plans than it would cost to cover the same beneficiaries under traditional Medicare. In some cases, it is as high as 50 percent more. That is $12 billion a year more than if these beneficiaries stayed in Medicare. Basically, we are giving a $12 billion subsidy to these companies.

Again, don't take my word for it. This is from a June 2009 MedPAC report:

> We estimate that in 2009, Medicare paid about $12 billion more for enrollees of [Medicare Advantage] plans than it would if they were in [fee-for-service] Medicare.

A $12 billion slush fund. We are saying we are going to reduce some of those subsidies. I hear my friends on the other side: My gosh, Medicare is going to take away all these benefits, and all that other kind of stuff. Not necessarily. Right now we know, according to CBO, our bill will lower seniors' Medicare premiums by $30 billion over 10 years.

Then the other side says: But if you cut these Medicare Advantage payments, you will see their benefits cut.

That is absolutely not true. All Medicare plans, whether traditional Medicare or private, must offer all required Medicare benefits. Here is the kicker. If, in fact, there are some cuts made in Medicare Advantage, then these private companies that are making $12 billion in their slush fund, maybe rather than cutting benefits, maybe they will decide to cut their CEO salaries from $12 million a year to $10 million a year. Maybe they will decide instead of three or four corporate jets, they only need one. Maybe they will start reducing some of the profits they are making, huge profits they are making off of the taxpayers and off of Medicare payees right now.

Again, if we cut the Medicare Advantage Program, I guess my friends on the other side would say, No. 1, they can continue to pay their CEOs $12 million a year salaries. They can continue the corporate jets. They can continue to have fancy buildings. They can continue to have outrageous profits. But they will have to cut Medicare. That is what the other side is saying.

We are saying: No, cut the CEO salaries. Cut the enormous profits. Cut those corporate jets. Cut all of that stuff you are using the slush fund for, but keep the benefits for Medicare.

As I said, under present law they cannot cut the basic Medicare benefits. No senior anywhere in America will lose their core Medicare benefits under our bill. Let's be clear about that. If they did, AARP, the National Committee to Preserve Social Security and Medicare, and the National Alliance for Retired Americans would never be supporting our bill.

Lastly, according to an economic survey done at Boston University, they extensively analyzed Medicare Advantage payments and found that just 14 percent of the additional funds these private plans have received have gone to benefit Medicare enrollees. The vast majority of the payments, 86 percent, go to profits, CEO salaries, corporate jets, all these other things, or some of it may go to things such as gym memberships, spa memberships. I raised the point the other day. Why should my Medicare beneficiaries in Iowa have to pay more in Medicare so that a Medicare beneficiary, say, in Arizona can go to a spa and have it paid for by Medicare Advantage, paid for by the subsidies of $12 billion that we give them that come both from taxpayers and from Medicare recipients right now? I don't think it is fair for my seniors in Iowa to have to pay for that.

A lot has been said about all the people who are in the Medicare Advantage plans. I looked up the figures. Right now, nationally, only 18.6 percent of all enrollees are in Medicare Advantage, a little less than one out of five. In my State, in Iowa, it is 10 percent, 1 out of every 10. Why is that? We don't have a lot of spas in Iowa. We don't have those fancy things like they have in Florida and Texas and Arizona and California, wherever else all this stuff is going. What my seniors need is the peace of mind of knowing that Medicare is going to be there for them in the future. They need to know they are going to get the benefits we have put in this plan that are in our bill and that will help Medicare beneficiaries.

Here is what they are. AARP says:

> The new Senate bill makes improvements in the Medicare program by creating a new annual wellness benefit, providing preventive benefits and, most notably for AARP members, reducing drug costs for seniors who fall into the dreaded Medicare doughnut hole.
>
> The bill also makes improvements on age rating, a discriminatory practice that allows insurers to charge exorbitant age-based premiums to older Americans.
>
> Finally, AARP strongly supports provisions in the Senate bill to strengthen long-term services and supports. We also applaud inclusion of provisions to improve access to Medicaid home and community-based services.

All is in our bill, all of which would fall if we adopt the McCain amendment. I urge colleagues not to listen to the rhetoric from the other side. Listen to those who really do represent seniors. Make sure we preserve and protect the basic Medicare functions for seniors and for those who are about to retire. You will not get that through Medicare Advantage. If Medicare Advantage wants to exist and compete on a level playing field, God bless them. Go ahead and get it done. That is what we were promised when Medicare Advantage came through here. I remember. Competition. But what we found is, we had to cough up an additional $12 billion to subsidize them.

It is time for us again to say no to the fearmongers, to those who are trying to strike fear in seniors. It is time to stand up, support the Bennet amendment, which makes very clear that any savings that come from Medicare has to go back into Medicare. That is the way it ought to be. That is what is in this bill. The Bennet amendment makes that crystal clear. The McCain motion does away, basically, with all of the protections, all of the things we have worked so hard for since 1965 to provide. The McCain motion, when you strip away all the verbiage, really what it does is, it basically takes us back to pre-1965 when we didn't even have Medicare. That is the kind of intent behind it.

Mr. BROWN. Will the Senator yield for a question?

Mr. HARKIN. I am glad to yield.

Mr. BROWN. I thank the Senator for his incredible leadership on this issue and the public option, affordability, and on prevention and wellness.

I have listened to the debate with Senator MCCAIN and others on Medicare. It seems what they are protecting is not Medicare but the huge insurance company subsidies when President Bush moved to privatize Medicare. It used to be the insurance companies told us they could do their part of Medicare, one-fifth, one-sixth of Medicare; that they could do it more efficiently even though insurance companies have a 15-, 20-percent administrative cost overhead and Medicare's is 3 or 4 percent or 2 percent.

The PRESIDING OFFICER. The Chair reminds the Senator, the majority time has expired.

Mr. BROWN. I ask unanimous consent for 2 additional minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BROWN. Much of what they are trying to protect is insurance company subsidies, not Medicare benefits which their party has opposed for much of the last 40 years, including its creation.

Mr. HARKIN. As I said earlier, what they are talking about in preserving these benefits and this subsidy for Medicare Advantage is the big CEO compensation packages, the corporate jets, the fancy buildings, the high profits, somewhere between 30 percent and 200 percent profits made by these companies that are providing Medicare Advantage. That is what the Republicans are trying to protect, not the Medicare recipients.

Mr. BROWN. I thank the Senator.

The PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. BENNETT. Mr. President, I listened with some interest to the comments made when I came on the Senate floor. I simply want to make this one observation about Medicare Advantage. President Obama promised that Americans who have coverage they like would not lose the coverage they have. There are a number of Americans who have Medicare Advantage. They like it, and they want to keep it. This Congress is about to say: No, you can't. This Congress, through this bill, if it passes, is going to eliminate Medicare Advantage. Frankly, the people who go after Medicare Advantage because they like it are going to be the ones who are disadvantaged. They are going to be the ones who will see President Obama's pledge violated.

Frankly, I don't think they much care about how much an executive is paid or what happens in the company. They care that they have coverage they like, coverage they are paying for, coverage they have chosen, and they are being told by the Federal Government they cannot have what they want.

There is another aspect to this that I would like to explore in the time I have. We keep hearing so much about the CBO and all of the scores the CBO is pointing out along with rhetoric that says we can't afford to wait, we need a solution now, the status quo is unacceptable. I would like to point out that the status will remain quo for 4 years if this bill passes. In the budget smoke and mirrors that have been put into this bill in order to make it look as if it costs less money, they make the effective date in 2014, so there will be 4 years after the passage of this bill where Americans will not see any kind of change in their plans. What they

will see is an increase in their premiums. They will see an increase in taxes.

Why do I say that? Between January of 2010 and January of 2014 there will be four open seasons in which plans can be changed. As the taxes start to hit, as the costs start to hit, those companies that are involved in offering these plans will say: OK, we have to get ready for the expenditures. What do we do? We have four open seasons in which to change our plans before this thing hits.

Obviously, that cannot be scored by CBO because CBO does not know what changes will be made. But do we really think we can go through four open seasons with no change whatsoever in the face of this enormous change that will hit in January of 2014? Do we really think everything is going to remain static? That is what the CBO computers are. Do we really think the $500 billion they want to take out of Medicare to help pay for this will not be hashed over again and again?

One of two things will happen. No. 1, the Democrats will blink in the face of the anger of senior citizens and say: We really didn't mean it. Yes, the bill cuts Medicare by $500 billion, but we really didn't mean it. We have 4 years in which to fix it; that is, 4 years in which to replace that $500 billion. Of course, when that $500 billion is replaced, if that is the way they decide to go, then we will know that the numbers we are getting out of CBO are completely phony. Then we will know the statement that this bill is revenue neutral is a nonstarter. Then we will know there was never any intention to try to deal with this cost.

Suppose future Congresses stand firm and say: Yes, we are going to stand firm in this 4-year period. We are going to stand firm against the anger of senior citizens who are seeing their Medicare benefits get cut. We are going to take the $500 billion out of Medicare. Then we will see the promises that are being made around here—that there will be no cut in Medicare services—all disappear.

I hear people say: We are not cutting benefits. We are just cutting payments to providers. That statement is being made over and over again on the other side of the aisle: We are not cutting benefits. We are going to take that $500 billion away from the providers, but the benefits will remain the same.

In my State, I have plenty of providers that are on the edge, right now, financially. They are on the edge of going out of business, right now, financially because of the cuts that have been made in Medicare in the name of cutting down payments to providers.

What happens to the people who are in a nursing home that is currently dependent upon Medicare payments in order to survive if they come in and say: All right, we are not going to do anything to the benefits these people are entitled to in this nursing home, we are just going to cut enough payments to the nursing home that the nursing home goes out of business. What happens to the people who are in the nursing home under that circumstance? Well, they are going to have to go someplace else and there is going to have to be money to pay for them to go someplace else and the money is going to have to flow through Medicare someplace else and then we are back to the first option I talked about, which is we were not serious when we said we were going to take $500 billion out of Medicare. We were not serious. In order to make sure you do not lose your benefits, we are going to have to start reinvesting in some of these providers. We have seen providers go out of business because of the cuts into Medicare. We need to start putting that money back into Medicare. Then we are back into the circumstance we have been talking about all along: This thing is not paid for.

One final point I wish to make: We had a hearing today with the Chairman of the Federal Reserve. Ben Bernanke is up for reappointment and, of course, the entire conversation was about the economy and what is the future of the economy. There were a number of people who had a conversation about the past, but I wished to focus on the future.

I pointed this out to the Chairman and asked for his comments with respect to the future of our economy. Most of my constituents do not understand what I am about to say. Frankly, most of the people in the press do not understand it, and maybe even some Members of this body do not understand it. When we talk about the Federal budget, two-thirds of the Federal budget is beyond the control of this Congress. Two-thirds of the Federal budget is on autopilot, unless this Congress changes entitlements.

Somebody says: Well, what does this word ''entitlement'' mean? Why do you talk about entitlements? Entitlement means, by law, these individuals are entitled to this money, whether we have it or not. The Federal Government has made a contract with them. All right, it is a social contract rather than a legal contract, but it is as binding politically where the Federal Government has to spend the money, whether it has it or not.

Indeed, that is what we have seen in fiscal year 2010. The budget we passed said revenues are going to be $2.2 trillion and entitlement spending is going to be $2.2 trillion, which means every function of the government—our Embassies overseas; our troops, wherever they may be; education; national parks; whatever it is—every dime will have to be borrowed in fiscal year 2010, every single dime because every penny coming into the Federal Government is already programmed to go out, without coming through the Congress. It does not go through the appropriations process. We do not get to vote on it. People are entitled to receive this money, and it is going to go out there.

What are we talking about? We are talking about creating a new entitlement, a very expensive new entitlement. How are we going to pay for it? According to this bill, we are going to pay for it by transferring money from an existing entitlement. Anyone who thinks that is what is going to happen, in the face of the anger that is being generated by people who read about this, believes a fairytale.

The whole notion of trying to balance the cost of this tremendous new entitlement by somehow a bookkeeping entry that says we will take it out of the Medicare account and we will put it in this account, and the computers that do not think—the computers simply compute—will say: Well, then, if you put it in this account, then this account is revenue neutral. But the government's account is not revenue neutral. This thing is going to cost $500 billion, wherever we get the money. It is a cynical ploy, smoke and mirrors of the worst kind, in a budgetary bait and switch, to say we are going to take this out of Medicare.

I hear from my constituents—I hear from people who are not my constituents who recognize me as a Senator in airports and other places—as they say, increasingly: Do not pass this bill. We see it in the polls, but we see it in the passion of the people who come up to us and let us know how firmly they are opposed to this bill. The American people do not want it, and the American people are right.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I would like to also make a statement related to the amendment that is being presented by the Senator from Colorado. Speaking for several Members on my side—hopefully, for all the Members on my side—we are very concerned, as I think we have all made clear by now, that the Medicare savings in this bill are being used not for preserving Medicare but, instead, are being used to finance the creation of a new Federal entitlement program.

My understanding of the purpose of the amendment of the Senator from Colorado is to indicate that Medicare savings will be used for extending the solvency of Medicare and the trust fund, reducing Medicare premiums and other cost sharing for beneficiaries, and to improve or expand Medicare benefits and access to providers.

Nobody can argue with that purpose the Senator has expressed or his amendment expresses. But the concern on our side that we have with this amendment is it does not require that the savings from Medicare would only—with emphasis upon the word ''only''—be used for that purpose.

As the Congressional Budget Office has made clear, the cuts in Medicare in this bill are not being used solely for Medicare, as the Senator's amendment suggests, but, instead, are being used

mostly to fund the creation of an entirely new and separate subsidy program. For the Senator to accomplish what he intends to accomplish would require entirely different language to ensure that savings from Medicare in this bill would only be used to protect Medicare benefits for seniors, as the law now expresses.

The right approach would include language making sure seniors have the same access as they have today, to home health services, skilled nursing facilities and services, hospice care, hospital services, preventive benefits, and the benefits provided in the Medicare Advantage Program. So the Senate, it seems to me, should also ensure that Medicare savings in this bill are not being siphoned off to finance a new and separate entitlement program.

It is very clear to me—and I hope we are able to make it clear to people, all 100 Senators—that the Bennet amendment, as written, does not protect Medicare.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. BAUCUS. Mr. President, I do not think I have any time, but I ask unanimous consent that as to the time I do have after 2 o'clock, I can take 2 minutes of that so I can ask a question of my good friend from Iowa.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I might ask my friend from Iowa, Senator GRASSLEY, a question, if he is available for a question. I am taking time.

Mr. GRASSLEY. Mr. President, I will take a short minute to respond to a question. But our side has 7—

Mr. BAUCUS. I understand. I do not want to cut into that time at all.

Mr. GRASSLEY. Could we discuss this maybe a little bit later, what you brought up?

Mr. BAUCUS. I am taking it off my time, not your time.

Mr. GRASSLEY. OK.

Mr. BAUCUS. Is it true the Congressional Budget Office said this bill, over 10 years, is not only deficit neutral but actually decreases the budget deficit by about $130 billion? Is that true? Is that what the Congressional Budget Office said?

Mr. GRASSLEY. That is true. But I do not think the Senator wants to go down that road because, do not forget, there are 6 years of programs, of expenditures, and there is 10 years of revenue coming in. If you want to play that game, you can pay down the entire national debt.

Mr. BAUCUS. Well, I do not know—to be totally fair and respectful to one of my very best friends in the Senate—to cover that point, isn't it also true the Congressional Budget Office said in the second 10 years this bill will reduce the budget by one-quarter percent of GDP? Isn't that also true, according to the Congressional Budget Office?

Mr. GRASSLEY. I cannot respond to that because I do not know that for sure. So I do not want to respond. But if you tell me, I tend to believe everything you tell me.

Mr. BAUCUS. We trust each other. We both trust each other. That is what the letter says.

Thank you.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Mr. MCCAIN. Mr. President, I ask unanimous consent that my colleagues and I—the Senator from Tennessee, Mr. ALEXANDER; the Senator from Oklahoma, Mr. COBURN; Senator LEMIEUX from Florida; Senator ENZI; and Senator CRAPO—be allowed to engage in a colloquy.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. MCCAIN. Mr. President, how much time do we have?

The PRESIDING OFFICER. The minority has 3 minutes 42 seconds; and then, on top of that, at 2 o'clock, the Senator from Arizona controls 17½ minutes.

Mr. MCCAIN. Thank you. I will let those minutes run together, if there is no objection.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MCCAIN. Mr. President, I wish to begin our conversation with a brief comment about the American Association of Retired Persons, known as the AARP, that has now come out against this amendment, incredibly.

It is a fascinating history of that liberal Democratic group because, in 1993, when we had some savings in Medicare, the AARP said:

> If we're talking about Medicare cuts alone as a way of financing health reform, we would fight that with all our strength—we've gone as far as we can go down that road.

The AARP, on $6.4 billion Medicare cuts in 2005, said: ''Strongly Opposes.'' They said the:

> . . . conference agreement . . . undermines the critical protections built into both the Medicaid and Medicare programs. Instead of . . . shared sacrifice to achieve budgetary savings. . . .

Every time there has ever been a savings in Medicare or Social Security in any way, shape, or form, the AARP has come out against it, except now when there is the most massive cut in Medicare in history and a transfer of those funds to a vast new $2.5 trillion entitlement program. It was described as $2.5 trillion just yesterday by the chairman of the Finance Committee.

I say shame on the AARP. I say to my friends, especially those who are under the Medicare Advantage Program, the 330,000 in my State, for whom, admittedly, they are going to cut their Medicare Advantage benefits, take your AARP card, cut it in half, and send it back. They have betrayed you.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized.

Mr. COBURN. Mr. President, the chart behind me shows the cuts in Medicare that are in this bill. We have heard all sorts of arguments. I have a few rhetorical questions for my colleagues and my friend, the President of the United States.

There is no question Medicare Advantage costs too much. I have agreed to that with the chairman of the Finance Committee. But you cannot say that coordinated care does not improve the care of seniors, and that is going to be cut. You cannot say that eyeglasses and hearing aids are not going to be cut, and they do improve the care. You cannot say to seniors who cannot afford a supplemental policy, who have Medicare Advantage, they are not going to lose some of their care. They are. In fact, 2.6 million, according to the Congressional Budget Office, are going to lose that very care—not some of it, all of it. They are going to lose that advantage under this legislation. The answer to the question, will this impact seniors care, is yes. We have heard these cuts aren't going to impact anybody or the only people they are going to impact are the insurance companies. Well, I am all for impacting the insurance companies, but I don't want to impact patients negatively.

So we have cuts to Medicare, including hospitals, of $134.7 billion; hospices, $7.7 billion; nursing homes, $14.6 billion; Medicare Advantage, $120 billion; home health agencies, $42.1 billion; and then you say you are not going to do anything to impact the care of seniors. My colleague from Iowa, whom I love, disputed my statement about the fact that the life expectancy is going to go down under this bill. He has never practiced medicine a day in his life. I know what goes on inside hospitals. When you cut $130 billion out of the hospitals, the time you are going to wait for me, the time you wait after you push your call button is going to get extended and the complications from that are going to result in decreased quality of care and shortened life expectancies. There is no question about it.

So we can play the game, but the real thing Americans ought to know is almost $500 billion of spending on Medicare patients today is going to go by the wayside to be spent on a new entitlement, on a brandnew entitlement.

The PRESIDING OFFICER (Mr. BROWN). The Senator from Idaho is recognized.

Mr. CRAPO. If the Senator from Oklahoma will respond to a question, he is a physician, and he has very well pointed out how the cuts to Medicare Advantage will reduce benefits to senior citizens. The impacts on the hospitals and home health care and the skilled nursing facilities and so forth will be reduced services. I am aware of a June 2008 report from the Medicare Payment Advisory Commission, MedPAC, which said 29 percent of Medicare beneficiaries they surveyed who were looking for a primary care physician had trouble finding one who would treat them. A similar survey in Texas showed that in that State, only

58 percent of the State's doctors would be willing to take a new Medicare patient, and only 38 percent of the primary care doctors accepted new patients.

So my question is, in addition to the reduction of benefits, in addition to the reduction of access to hospitals and skilled nursing facilities and so forth, won't these cuts and the impact on Medicare also represent a lack of ability by Medicare recipients to literally find physician care?

Mr. COBURN. There is no question, to answer my colleague from Idaho, that if it doesn't eliminate the ability, it will deny by delaying the ability. Care delayed is care denied. All you have to do is read all of the tragedies that have gone on in this country for people who have delayed care which has resulted in large complications for that individual.

Mr. ENZI. Mr. President, I wish to raise a point as the accountant around here. You have mentioned some ways to cut Medicare to pay for this. Actually there are only two ways you can pay for a government program. You have to do it through cuts or through taxes. I don't think there is anybody in America who believes you can do $1 trillion worth of new programs and have them all paid for, unless you steal somewhere. That is what we are doing from Medicare. We say that is not going to affect Medicare. If you eliminate the DSH payments which are part of this, it is going to put some Wyoming hospitals out of business. I can assure you that if those seniors can't go to a hospital in their town, they are going to consider that a benefit cut. They are going to be upset, and they ought to be.

The same with nursing homes. If you cut back on nursing homes, the people who have to move to another town for a nursing home—because all of our towns don't have more than one nursing home—puts quite a burden not only on the patient who isn't going to get to see their family as much, but also on the family who has to travel a long way to see the patient. So I don't think we ought to be paying for the new programs by doing this when Medicare needs an extended life.

I am always fascinated when they explain that this will extend the life of Medicare because, yes, if you cut payments to everybody, that maybe saves money and extends the life of it, if we did that. Is there anybody who thinks we are going to cut the doctors over the next 10 years by $250 billion? No, we are not going to do that. We never have.

Mr. COBURN. Would the Senator yield for a moment?

Mr. ENZI. Yes.

Mr. COBURN. My one criticism of my colleagues in writing this bill is I think there is money we can save in Medicare. It is called waste, fraud, and abuse. A Harvard professor who studies this says there is at least $125 billion a year in fraud. We have had several studies that say it is anywhere from $100 billion to $175 billion a year. There is nothing in this bill to eliminate fraud. What we are doing is we are taking care from seniors instead of taking the money from the fraudulent actors in the health care system.

Mr. ALEXANDER. Mr. President, if I may say to the Senator from Arizona, I greatly appreciate his making this amendment, because there is so much said here on the Senate floor that must be hard for many people to follow. But one thing I believe everybody agrees on is there are going to be $465 billion in cuts to Medicare over the next 10 years, period. Everybody agrees with that. The President of the United States has said we are going to pay for this new health care bill with one-half from Medicare cuts and one-half from taxes. Everyone agrees with that.

What Senator MCCAIN's amendment is saying is two things—and Senator MCCAIN, let me see if I characterize properly your amendment, because it is a very simple amendment, as I read it. It is saying, send it back to the Finance Committee and say, bring the health care bill back without the Medicare cuts, without these cuts to hospitals, cuts to hospices, cuts to nursing homes, cuts to Medicare Advantage, and cuts to home health agencies.

Second, if we are going to take money from grandma's Medicare, let's spend it on grandma. Let's take the savings we find in Medicare and absolutely make sure we spend it on Medicare, which the trustees have said is likely to go broke between 2015 and 2017.

Did I correctly characterize the Senator's amendment?

Mr. MCCAIN. Absolutely.

Mr. ALEXANDER. And does the Senator recall a few years ago when the Republicans suggested saving $10 billion over 5 years in Medicare, the majority leader said that was immoral, and that other Democratic Senators thought it was awful? If $10 billion in savings to try to make Medicare stronger is immoral, what is spending nearly $½ trillion on a new program called?

Mr. LEMIEUX. I wonder if I could ask a question.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. LEMIEUX. I have a question for my colleague from Tennessee. I am new here. This is all new to me. I thought the goal was to reduce health care costs while trying to provide health care for more Americans. We are taking money out of health care for seniors to create a new entitlement program. We are taking money out of nursing homes, home health care, hospitals, and a program called Medicare Advantage that people in my State I know enjoy very much. How does it make sense that we are taking money out of Medicare to start a new health care program?

Mr. ALEXANDER. Well, if I may say—and then I think maybe others could respond—if you are going to spend $2.5 trillion a year, you have to get the money from somewhere. What the Democratic health care bill does is get it three places. One is from seniors, one is from taxes, and one is from the grandchildren of seniors; that is, debt. It comes from those three places.

What we heard earlier this week was the Congressional Budget Office saying the total effect of that $2.5 trillion is that for most Americans, premiums would continue to go up as they already are, and that for people who go into the individual market they will go up even more—they will go up even more—except there will be some subsidies for a little over half of those people, and where is the subsidy money coming from? It is coming from Medicare. So that is the answer to the question.

Mr. LEMIEUX. It would seem to me—and again, I am new to this process—that 100 Senators would vote for Senator MCCAIN's proposal because everyone in this Chamber believes we should strengthen Medicare. Who could be for taking money out of Medicare if we don't need to? These are two separate issues. Shouldn't every Senator in this Chamber say let's send this back to the Finance Committee so those cuts can be restored and we can start over and take a step-by-step approach? That only seems fair to me.

Perhaps my colleague from Oklahoma could comment on that.

The PRESIDING OFFICER. The Senator from Oklahoma is recognized.

Mr. COBURN. I thank the Chair.

We are in trouble in Medicare in this Nation. Everybody knows it. We have made promises. The unfunded liability on Medicare is $79 trillion. For us to take $½ trillion, no matter what the Enron accounting says afterward, the fact is we are going to reduce that; we are going to make that worse. We may not make it worse next year or the year after, but we are going to make it worse. It is going to be worse for seniors, but it is also, as the Senator from Tennessee said, going to be extremely worse for the seniors' kids and grandkids. Not only have we done that, we have raised the taxes in Medicare on a certain group of people and we are going to take that money and not put it in Medicare; we are going to take that money, a Medicare tax, and create a new entitlement.

So the Senator from Florida is absolutely right. If you vote against the McCain motion you are saying you want to cut $½ trillion out of Medicare and that it will have no effect whatsoever on the care.

I remind the Senator from Florida, there are 1 million people on Medicare Advantage in the State of Florida, 1 million people who are going to lose benefits under this bill. One million people in the State of Florida will lose benefits under this bill.

Mr. ALEXANDER. Mr. President, I would ask the Senator from Oklahoma, who is a physician himself, if one of the

effects of cuts in Medicare is to make it more difficult for people who are on Medicare to see a doctor. It is like giving somebody a bus ticket and not having a bus.

I have been reading in the newspapers, for example, in the Washington Post last month, that the Mayo Clinic, which is often held up as an outstanding example of a clinic that keeps costs under control, has announced it no longer will accept Medicaid patients from Nebraska and Montana, and some Mayo clinic facilities in Arizona and in Florida are beginning to say no more Medicare patients.

Is this what the Senator from Oklahoma thinks could be happening at other hospitals and centers, even very good ones such as the Mayo Clinic where they allegedly keep costs at a reasonable level?

Mr. COBURN. I think that is entirely possible. I don't know that to be factual as of yet. What I do know is we are going to have 44 million baby boomers in the next 12 years jump into Medicare and we are cutting Medicare. We are going to have 44 million baby boomers jump into Medicare. I am one of them. We are going to cut the amount of available funds from Medicare under this bill.

Mr. ENZI. Mr. President, I wish to ask the Senator from Idaho what he thinks will happen with these Medicare cuts as they affect jobs and the economy. That is one of the biggest things on people's minds right now, jobs and the economy. We are concentrating on something here where we are going to maybe make a difference, even though CBO says it won't be much of a difference.

Mr. CRAPO. I thank the Senator from Wyoming for that question, because as we have already reviewed, there will be major cuts in benefits to Medicare, to the Medicare Advantage Program. There are going to be major reductions in access to Medicare, in terms of access at hospitals and skilled nursing homes and facilities and home hospice and other care.

But one of the other things we haven't focused on—and it is kind of interesting that today is the big White House jobs summit—what is going to happen as a result of these Medicare cuts. In addition to the reduction of access and care and benefits to seniors, we are going to lose jobs. I have had in my office here representatives of nursing and home health care facilities from Idaho who have told me that if this bill is adopted, a number of those facilities are simply going to have to go out of business or they are going to have to dramatically reduce the services they provide, meaning that the nurses and the other caregivers who work there will no longer have jobs. That is part of the way our senior citizens will lose access because there will simply be fewer places, fewer physicians, fewer facilities that will take Medicare patients with this kind of an attitude of the Federal Government toward funding of Medicare.

In the end, what do we have? We have a massive expansion of government, $2.5 trillion for a massive new entitlement program, along with which come these incredible government controls over the economy, as well as the creation of a new government insurance company, funded by $½ trillion, almost, of Medicare cuts, $½ trillion in taxes, and a massive debt, an unfunded mandate pushed on to the States.

That is one of the reasons why I think the Senator from Arizona was so wise in bringing this motion as the first step in focusing on one of the first fixes that needs to be made to this bill. Let's step back. Let's not pay for a brandnew $2.5 trillion entitlement program on the backs of our senior citizens.

Mr. ALEXANDER. How much time is left?

The PRESIDING OFFICER. The Senator from Arizona is controlling the time, and there is 3 minutes 20 seconds remaining.

Mr. MCCAIN. Mr. President, I mentioned the AARP and their opposition to this amendment. There is an organization called 60 Plus that has millions of supporters and members. They also feel very different from the AARP. Their message is:

> Soon you [the Senate] will vote on the McCain motion to commit with instructions. The motion would commit it to the Senate Committee on Finance—

Et cetera.

> I and the 5.5 million supporters of 60 Plus urge you to support this motion. The Patient Protection and Affordable Care Act is nothing of the sort. It would cut Medicare by $500 billion. These cuts would harm seniors who have paid into the program and expect it to be there to help them with their health care needs. At 60 Plus, we pride ourselves on advocating for the best interests of seniors. That is a ''yes'' vote on this motion.

Let's pay attention to 60 Plus.

Mr. COBURN. I have a question. Does 60 Plus sell supplemental insurance policies to seniors?

Mr. MCCAIN. I don't believe so.

Mr. COBURN. But AARP does. I wonder why people want seniors off Medicare Advantage.

Mr. MCCAIN. Most people believe this would be a windfall of tens of millions of dollars for AARP if the legislation is passed as presently crafted.

Mr. ALEXANDER. How many Medicare Advantage members are there, for example, in Arizona? Is it a small program or a large program?

Mr. MCCAIN. Our figures are that 330,000 people in my State of Arizona are on Medicare Advantage. I noticed yesterday, when the distinguished chairman of the Finance Committee and the Senator from Connecticut were talking, they were disparaging the entire program, saying how it wasn't any good, talking about the cost overruns and saying it was a bad program. They have opposed it from the start.

So the message to the 330,000 Americans in Arizona who are on Medicare Advantage is that they are out to get you.

Mr. CRAPO. According to the Senator from Tennessee, it is my understanding that nationwide it is about one-quarter of all Medicare beneficiaries. About one in four Medicare beneficiaries in America will see their benefits cut. All Medicare beneficiaries will see their access cut. So these problems we are talking about are not just limited in their impact.

Mr. MCCAIN. I will respond again. There are cost problems with Medicare Advantage, but those cost problems can be fixed. Those cost problems can be brought under control. But the fact is, to do away with a program that allows them a choice in how they receive their care is, of course, again, an effort to have the government make the decisions for people, which flies in the face of everything we stand for and believe in.

Mr. ALEXANDER. I may say to the Senator from Arizona, I have heard our friends on the other side say Republicans are scaring seniors about Medicare cuts. Mr. President, it is not Republican Senators who are scaring seniors about Medicare cuts; it is the Democratic health care bill that is scaring seniors, because there are $½ trillion of Medicare cuts that will pay for half of this program, and they are outlined on this chart, as the Senators have discussed.

The PRESIDING OFFICER. The time of the Senator from Arizona has expired. The senior Senator from Montana has 15 minutes 50 seconds.

Mr. BAUCUS. I will yield myself about 10 minutes. The Senator from Tennessee says this is going to hurt seniors. Let's ask the senior organizations what they think about that.

Let's also look at this organization called 60 Plus. What does the AARP say in the letter to Senator REID, dated December 2? It talks about this legislation:

> The legislation before the Senate properly focuses on provider reimbursement reforms. . . .

I am sorry all my colleagues have fled the Senate. I would like for them to stay and listen to this. I would like to hear their response. But they have just fled the Senate after making sound bites.

Mr. ALEXANDER. Mr. President, I am here.

Mr. BAUCUS. I will take my time. The AARP letter, dated December 2, states:

> The legislation before the Senate properly focuses on provider reimbursement reforms. . . .
>
> Most importantly, the legislation does not reduce any guaranteed Medicare benefits.

That is AARP. All this is scare talk about ''grandma.'' With all due respect to my friend from Tennessee, he says that. He has been using that phrase a lot. But AARP says that grandma is fine. AARP says:

> Most importantly, the legislation does not reduce any guaranteed Medicare benefits.

It doesn't reduce any benefits, according to AARP. Going on:

AARP believes that savings can be found in Medicare. . . .

The savings in Medicare will extend the solvency of Medicare. I am sure my friend from Tennessee knows the actuary said this legislation extends the solvency of Medicare, helps Medicare. The benefits go on longer than the status quo. Also, it does so, according to AARP, by eliminating waste and inefficiency and aggressively rooting out fraud and abuse. The last sentence is:

We therefore urge you to oppose the McCain amendment to recommit. . . .

The AARP says this hurts seniors, the McCain motion to commit. I think the job of the AARP is to figure out what is best for seniors. That is their conclusion.

It is not just AARP's view. There is another letter. This is from the National Committee to Preserve Social Security and Medicare. They say basically this legislation doesn't cut Medicare benefits. Again, this is the National Committee to Preserve Social Security and Medicare. They say, rather, this legislation includes provisions to ensure that seniors receive high-quality care and the best value for their Medicare dollars. That is a very reputable senior organization. AARP is a very reputable senior organization. The National Committee to Preserve Social Security and Medicare is a very reputable organization. That is what they say.

Who is this 60 Plus association I have heard referred to? Let me just tell my colleagues what 60 Plus really is. I will read this. This is from Wikipedia, and it may not be accurate. It says this about 60 Plus:

The 60 Plus Association is an American conservative advocacy group based in Arlington, Virginia, that bills itself as the conservatives' alternative to the AARP.

That makes good sense because over the years it has sought to privatize Social Security. 60 Plus, over the years, has sought to privatize Social Security. They want to end the Federal estate tax. They also want to strengthen gun rights, but that is not relevant.

According to the AARP—

And this is a bit biased—

the 60 Plus Association employed the talents of conservative direct mail mogul Richard A. Viguerie to solicit new members.

We all know who Viguerie is. 60 Plus is a very conservative organization. I don't think they are real interested in senior citizens. They have different fish to fry. Also, AARP criticized 60 Plus as being partisan because its issues and causes mirror those of only one of two major parties, the Republican Party.

A final criticism leveled by the AARP [about 60 Plus] is that because it lists no dues-paying members and [get this] receives the majority of its contributions from the pharmaceutical industry, the group is simply a front organization for the pharmaceutical industry.

I ask unanimous consent to have these letters in opposition to the McCain amendment, in support of the Bennet amendment, and the Wikipedia information printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

ALLIANCE FOR RETIRED AMERICANS,
Washington, DC, December 1, 2009.

DEAR SENATOR, The Alliance for Retired Americans, on behalf of its nearly four million members throughout the nation, opposes the motion by Senator John McCain to commit the Patient Protection and Affordable Care America Act, H.R. 3590, to the Finance Committee. We urge its prompt defeat by the Senate.

The McCain motion to commit would seriously undermine important, substantive, and positive changes in the health care needs of older Americans contained in the bill, none more important than proposed Medicare improvements. In fact, the McCain motion would increase health care burdens on Medicare beneficiaries in several instances. The McCain motion would, for the first time, subject Medicare Part D prescription drug premiums to means testing, causing a rise in premiums for many older Americans. In addition, the motion to commit would halt indexing to Medicare Part B physicians services premiums, causing even more seniors to pay higher premiums, which currently can be as much as $300 per month. Furthermore, the McCain motion would continue the wasteful Medicare Advantage overpayments that currently threaten the financial stability of the Medicare Trust Fund.

The Alliance supports provisions in the Patient Protection and Affordable Care Act that improve health care for older Americans such as allowing Medicare beneficiaries to keep their choice of doctors, lowering prescription drug costs, eliminating copayments for preventive screenings, expanding access to long-term supports and service, and providing assistance for pre-Medicare eligible early retirees. All of these improvements will not be possible should the McCain motion pass.

The legislation does not cut Medicare benefits. With the expected rising costs of Medicare, the legislation slows the rate of the program's growth without reducing benefits. The McCain motion would actually undercut fiscally responsible attempts to meet the challenges of providing health care for older Americans.

The Alliance for Retired Americans is committed to enacting legislation that improves the quality of life for retirees and all Americans. Defeat of the McCain motion to commit the Patient Protection and Affordable Care Act to the Finance Committee will directly benefit our members and more than forty million older Americans. If we can be of assistance, please contact Richard Fiesta, Director of Government and Political Affairs, at the Alliance.

Sincerely yours,

BARBARA J. EASTERLING,
President.
RUBEN BURKS,
Secretary-Treasurer.
EDWARD F. COYLE,
Executive Director.

AARP,
Washington, DC, December 2, 2009.

Hon. HARRY REID,
Majority Leader, U.S. Senate,
Washington, DC.

DEAR LEADER REID: AARP supports moving forward on health care reform, and we remain committed to enacting legislation this year that protects and strengthens Medicare, improves the delivery of health care and provides affordable insurance for all. Accordingly, we oppose the amendment offered by Senator McCain to recommit H.R. 3590 to the Senate Finance Committee.

As we have said from the outset, AARP supports a balance of revenues and savings with shared responsibility from individuals, employers and the government. With respect to Medicare, AARP supports policies to eliminate waste, fraud and abuse—and to improve the quality, value and sustainability of the program for current and future beneficiaries. The legislation before the Senate properly focuses on provider reimbursement reforms to achieve these important policy objectives. Most importantly, the legislation does not reduce any guaranteed Medicare benefits.

AARP believes that savings can be found in Medicare through smart, targeted changes aimed at improving health care delivery, eliminating waste and inefficiency, and aggressively weeding out fraud and abuse. Such changes will help strengthen Medicare's long-term financing without increasing costs for beneficiaries that make health care less affordable. Medicare provides critical health security to older Americans, and it is important that Medicare continue to deliver high quality care. As health care costs, including Medicare costs, continue to skyrocket, it is essential that we make changes to improve health care delivery, improve Medicare's financing, and ensure maximum value for our Medicare dollars. We believe that Medicare changes in this bill begin to move us down this path, without reducing guaranteed Medicare benefits.

With these savings, the legislation before the Senate takes important steps to improve access to preventive services for Medicare beneficiaries. However, more should be done to strengthen Medicare—including closing the Medicare Part D coverage gap, or ''doughnut hole,'' as pledged by the President.

We therefore urge you to oppose the McCain amendment to recommit, and we remain firmly committed to working with you to strengthen Medicare and enact comprehensive health care reform this year that improves access and affordability of health care for all.

Sincerely,

ADDISON BARRY RAND.

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE,
Washington, DC, December 3, 2009.

U.S. Senate,
Washington, DC.

DEAR SENATOR: On behalf of the National Committee to Preserve Social Security and Medicare's millions of members and supports, I am pleased to endorse the amendment of Senator Michael Bennet of Colorado which clarifies that H.R. 3590, the Patient Protection and Affordable Care Act, would improve the Medicare program as part of health care reform.

Senator Bennet's amendment puts into law two of the most important criteria the National Committee has been using when analyzing health care reform proposals. First, it states explicitly that the legislation would not reduce any of Medicare's guaranteed benefits. Second, it ensures that savings from Medicare would be used to improve Medicare. Improvements in H.R. 3590 include extending the solvency of the Medicare trust funds by five years, reducing the amount of future increases in premiums, eliminating cost-sharing for preventive benefits, making prescription drugs more affordable, and ensuring access to Medicare providers.

Protecting Medicare and Social Security has been the National Committee's key mission since our founding 27 years ago and remains our top priority today. Our members are no different than seniors all over this country who are nervous about rising out-of-pocket health care costs and are concerned about the Medicare savings in health care reform legislation. This is a legitimate concern, but it is important to put these savings

in perspective. The federal government will spend almost $9 trillion on Medicare in the next decade. The proposed savings of nearly $500 billion mean that the growth in spending will be reduced by about two percent over the next 10 years by eliminating wasteful spending and outright fraud.

The H.R. 3590, the Patient Protection and Affordable Care Act, includes savings that are designed to protect Medicare beneficiaries and improve the Medicare program. Senator Bennet's amendment expressly prohibits any reductions in guaranteed Medicare benefits and makes sure all savings are reinvested back into Medicare. I urge you to support the Bennet amendment which is important to Medicare beneficiaries and the solvency of the Medicare program.

Cordially,

BARBARA B. KENNELLY,
President & CEO.

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE,
Washington, DC, December 1, 2009.

U.S. Senate,
Washington, DC.

DEAR SENATOR: On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare, I am writing to express our opposition to the amendment offered by Senator McCain which would recommit H.R. 3590, the Patient Protection and Affordable Care Act, to the Senate Finance Committee with instructions to remove important Medicare provisions.

Much of the rhetoric from opponents of health care reform is intended to frighten our nation's seniors by persuading them that Medicare will be cut and their benefits reduced so that they too will oppose this legislation. The fact is that H.R. 3590, the Patient Protection and Affordable Care Act, does not cut Medicare benefits; rather it includes provisions to ensure that seniors receive high-quality care and the best value for our Medicare dollars. This legislation makes important improvements to Medicare which are intended to manage costs by improving the delivery of care and to eliminate wasteful spending.

The National Committee opposes any cuts to Medicare benefits. Protecting the Medicare program, along with Social Security, has been our key mission since our funding 25 years ago and remains our top priority today. In fact, these programs are critical lifelines to today's retirees, and we believe they will be even more important to future generations. But we also know that the cost of paying for seniors' health care keeps rising, even with Medicare paying a large portion of the bill. That is why we at the National Committee support savings in the Medicare program that will help lower costs. Wringing out fraud, waste and inefficiency in Medicare is critical for both the federal government and for every Medicare beneficiary.

The Senate bill attempts to slow the rate of growth in Medicare spending by two to three percent, or not quite $500 billion, over the next 10 years. However, it is important to remember that the program will continue growing during this time. Medicare will be spending increasing amounts of money—and providers will be receiving increased reimbursements—on a per capita basis every one of those years, for a total of almost $9 trillion over the entire decade. Even with the savings in the Senate bill, we will still be spending more money per beneficiary on Medicare in the coming decades, though not quite as much as we would be spending if the bill fails to pass.

America's seniors have a major stake in the health care reform debate as the skyrocketing costs of health care are especially challenging for those on fixed incomes. Not a single penny of the savings in the Senate bill will come out of the pockets of beneficiaries in the traditional Medicare program. The Medicare savings included in H.R. 3590, the Patient Protection and Affordable Care Act, will positively impact millions of Medicare beneficiaries by slowing the rate of increase in out-of-pocket costs and improving benefits; and it will extend the solvency of the Medicare Trust Fund by five years. To us, this is a win-win for seniors and the Medicare program.

The National Committees urges you to oppose the motion to recommit the bill to the Finance Committee with instructions to strike important Medicare provisions from health care reform legislation.

Cordially,

BARBARA B. KENNELLY,
President & CEO.

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60 PLUS ASSOCIATION
[From Wikipedia]

The 60 Plus Association is an American conservative advocacy group based in Arlington, Virginia, that bills itself as the conservatives' alternative to the AARP, (formerly the American Association of Retired Persons). Over the years, it has sought to privatize Social Security, end the federal estate tax, and strengthen gun rights. Current issues include opposing health care reform proposals; opposing federal energy standards; opposing the General Motors bailout; and opposing tax increases on those earning more than $250,000 per year. 60 Plus is a member of the Cooler Heads Coalition, an climate change denial organization.

According to the AARP, the 60 Plus Association employed the talents of conservative direct mail mogul Richard A. Viguerie, to solicit new members. The AARP has also criticized the 60 Plus Association as being partisan because its issues and causes mirror those of only one of the two major United States parties, the Republicans. A final criticism leveled by the AARP is that because it lists no dues-paying members and receives the majority of its contributions from the pharmaceutical industry, the group is simply a front organization for the pharmaceutical industry.

The organization's website provides positive reviews of its work by conservative politicians and commentators, including:

''The 60 Plus Association has helped provide the organization and momentum needed for repeal of the federal estate or death tax. I commend the Association for its efforts to abolish this unfair and burdensome tax.''—Rep. Ralph M. Hall (R–TX)

''Small business leaders recognize how counter-productive this tax really is. That's why they endorsed repeal of the death tax and why my bill is supported by the 60 Plus Association.''—Senator Jon Kyl (R–AZ)

''Jim Martin (who, by the way, gave George W. [Bush] his first political job) is the head of Washington, DC-based, The 60 Plus Association and one of the country's most vocal defenders of the tax rights of seniors.''—Mona Lipschitz, News Editor ''Talkers Magazine'' ''Sources'' Column March 2001.

LEADERSHIP

60 Plus is led by its President James L. Martin, a 73-year-old veteran of the U.S. Marines. Martin has previously led several conservative advocacy groups, and also was chief of staff for six years for former Republican congressman and senator, the late Edward Gurney of Florida. Martin also served as a member of President George W. Bush's health and human services transition team.

FUNDING

In 2001, 60 Plus received a total of $275,000 from the Pharmaceutical Research and Manufacturers of America, the group Citizens for Better Medicare, itself largely supported by the pharmaceutical industry, and three drug companies (Merck, Pfizer and Wyeth-Ayerst) plus another $300,000 from Hanwha International Corp., the U.S. subsidiary of a Korean conglomerate with chemical and pharmaceutical interests—amounts that made up about 29 percent of its revenue. ''We're not a front for anybody,'' James L. Martin, the chairman of 60 Plus, told the AARP Bulletin. ''I get money from lots of sources. I've received money from the pharmaceuticals—I wish it was more.'' 60 Plus does not provide any explanation of its funding on its website.

In 2003, President Jim Martin told the British Medical Journal that 60 Plus had 225,000 members, whom he would not disclose for privacy purposes. However, according to the organization's IRS Form 990, 91 percent of its $11 million in 2002 revenue came from one undisclosed source. The Public Citizen watchdog group suspects that the pharmaceutical industry was that source. According to the Washington Post, in 2002, 60 Plus received an unrestricted educational grant (which can be used as most needed) from the Pharmaceutical Research and Manufacturers of America. As recently as 2001, 60 Plus has not reported any member dues as revenue on its past tax returns, reported the AARP Bulletin.

60 Plus also earns income from sponsoring life insurance and health screening for its members.

HEALTH CARE REFORM

On August 7, 2009, 60 Plus released a TV ad to be aired on cable networks to inform viewers about the proposed U.S. health care reform legislation. Media Matters for America watchdog group found that the ad was largely false and used ''scare tactics'' to discourage voters from backing reform. To publicize the ad's launch, 60 Plus issued a press release titled ''Massive Medicare Cuts Await Elderly Says New Ad From Seniors Group'' that read in part, '' . . . The healthcare proposal touted by the Obama Administration means massive Medicare cuts in order to pay for healthcare 'reform'.'' 60 Plus provided no evidence of these supposed ''massive Medicare cuts.''

Mr. BAUCUS. Mr. President, I think it is pretty clear that the main organizations that care about seniors support this bill. Another organization—60 Plus—I don't know what they think. I guess they oppose it because they want to privatize Social Security, and they get most of the money from the pharmaceutical industry. I don't think they care about senior citizens, frankly, and certainly not as much as these other organizations.

I think it is also important to point out that this legislation is deficit neutral over not just the first 10 years but over the next 10 years. It is more than deficit neutral. This legislation generates a $130 billion surplus the first 10 years and, as we all know, reduces the budget by a quarter of GDP over the next 10 years. So this is not irresponsible; it is very fiscally responsible. It is strongly supported by the senior organizations that care for seniors. I might say, too, it is not raiding Medicare at all. It is strengthening the Medicare trust fund and it extends the solvency of the trust fund.

Therefore, I think, clearly, as AARP says, we should oppose the McCain amendment, which hurts Social Security beneficiaries, does not help them.

I yield such time as the Senator from Illinois needs.

The PRESIDING OFFICER. The Senator from Montana has 9 minutes 20 seconds, and the other side's time has expired.

Mr. DURBIN. Mr. President, I ask to be recognized for 5 minutes. If the chair would advise me when I have used that time.

I found it interesting, as I am sure the Senator from Montana has, to listen to all of the Republican Senators who have come to the floor to defend Medicare. I am sure the Senator from Montana has the same memory I do—that when it was created, it was created by the Democratic side of the aisle, with the general opposition of the Republican side of the aisle. They said it was socialized medicine, too much government, and it would fail. Now they are coming riding to the rescue of Medicare. We have a right to be skeptical about the arguments they are making.

Imagining these Republican Senators defending Medicare is trying to imagine a fish riding a bicycle. I cannot put it in my mind. But they are doing it. The Senator who sponsored this motion to commit, Senator MCCAIN, just a year ago, in the course of his Presidential campaign, called for eliminating $1.3 trillion in spending from Medicare and Medicaid. Now he comes to the floor and says this bill, which would reduce costs in Medicare by less than half of that amount over a 10-year period of time is irresponsible and the death knell of Medicare.

What is the real story? The real story is the Republican side of the aisle is defending the private health insurance companies—companies making generous profits from Medicare Advantage. This is a program offered by private health insurance companies to replace government-run Medicare. It turned out, in many instances, to have failed miserably. It costs more money because these private health insurance companies are taking profits out of the Medicare Advantage Program. So they have pleaded with the other side of the aisle to come to their rescue. They have sent in their best troops on the other side of the aisle, headed by the senior Senator from Arizona, who has said the first thing I will do is to protect these private health insurance companies and their rights to overcharge seniors in Medicare for Medicare Advantage.

He talks about the people now receiving Medicare Advantage, who may be disadvantaged and see a different policy in the future. What the Senator from Arizona and others don't dwell on is that everybody under Medicare today pays $90 a year more into Medicare to subsidize the private health insurance companies that offer Medicare Advantage. This is a tax—a tax—which the Senator from Arizona is trying to preserve. It is a tax on Medicare recipients.

The Senator from Arizona was right a year ago. We can take an honest look at Medicare and Medicaid and take money out of the system without disadvantage to the people involved.

I want to say to the Senator from Arizona and others that once we have dispatched his motion to commit, he will have a chance to vote for Senator MICHAEL BENNET's amendment. It could not be clearer. It has two parts. It says—repeating what this bill says, it says unequivocally:

No provision in this Senate bill can reduce any Medicare benefit guaranteed by statute.

Next paragraph:

Savings in Medicare from the bill will go to extend the life of the Medicare trust fund, lower part B premiums, or cost sharing, expands benefits, improves access to providers.

We know, and the seniors across America know, that left unattended and uncared for, Medicare may go broke in just a matter of 7 or 8 years. This bill before us will extend the life of Medicare for at least 5 years. It will put Medicare on sound footing which every senior and their families want to have. That is why AARP, the largest organization of senior citizens across America, has urged Members of the Senate in both parties to oppose the McCain motion to commit. That is why I stand today with the Senator who is chairman of the Finance Committee and say to my Republican friends, with their newfound love affair with Medicare, that they should reject the 60 Plus organization, this ''wise counsel'' they turned to that came up with the idea of privatizing Social Security.

How would you like to have had all your Social Security money in the stock market over the last 2 years? Boy, there is a great idea. Stick with this 60 Plus group if you like the notion of privatizing Social Security. Stick with AARP if you want Medicare to be strong, on sound financial footing.

I yield the floor.

The PRESIDING OFFICER. The senior Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I think it is appropriate to remind people of some of the provisions that are in this bill.

To repeat, because some people have listened to some of this debate and some have not and some might be tuning in right now, the fact is, without reform, without this legislation, Medicare is expected to go broke in the next 8 years. That is according to the Medicare trustees report. With this legislation, that is extended for at least 5 more years. That protects seniors. This legislation protects seniors. Without reform, that is, without this bill, costs will rise and seniors will be forced to bear more and more of the burden out of their own pockets. This legislation adds benefits for seniors. It does not take it away, as the other side implies.

Without reform, seniors will struggle to afford prescriptions in the doughnut hole. I remind my colleagues that this legislation will cut the cost of brand-name prescription drugs in half for seniors during that gap, the so-called doughnut hole.

It will also help provide more benefits in terms of annual wellness visits. When seniors go to the doctor for a colonoscopy, mammography, or other preventive screenings, they will not have copays, as is currently the case today. That is an added benefit this legislation provides for seniors.

Also, this legislation helps seniors who are eligible for both Medicare and Medicaid with access to home, community-based alternatives. A lot of our seniors would like that additional benefit. That is all in this legislation.

This legislation provides more benefits for seniors, not fewer. This legislation protects seniors; it does not harm them. This legislation extends the solvency of the trust fund rather than not.

I might also say—and I think the Senator from Illinois made a very good point—currently, seniors who are paying a Part B premium are really paying a $90 tax per year for those persons who are in Medicare Advantage. We know Medicare Advantage is overpaid. The Senator from Oklahoma, Mr. COBURN, agreed with me when I asked him just yesterday if Medicare Advantage was overpaid. He said, yes, it is overpaid by a very large margin. This legislation can adjust that overpayment.

I might also say, too, that the groups I mentioned support this legislation. But the main point I want to make is this: There are so many fundamental provisions in this legislation that really have not come out much in debate, a little esoteric but under the heading of ''delivery system reform.'' We must begin to change the way we reimburse doctors and hospitals so we are focusing much more on quality of care rather than quantity of care. Some of that is already happening in America without legislation. Basically, it is the nature of integrated systems. We all talked about them. I know Senators on the other side of the aisle also agree with this new trend where hospitals, doctors, nursing homes, and other groups get together and they coordinate their care. Their care is much more patient focused. We have to move much more in that direction.

This will go a long way once it starts kicking in—it is going to take maybe 3 or 4 years to finally have an effect—toward eliminating the waste in our current system. Estimates are we have between $200 billion to $300 billion to $800 billion annually in waste in the American health care system. That is the reason health care costs are so high for family, businesses, governments, whatnot. We have to begin to get that under control, and this legislation does that.

If we do not pass this legislation, we will be postponing the day when we have to begin to get some of these excessive costs under control, and then the problem will be much more difficult. An ounce of prevention is worth a pound of cure in medicine. It is also true in legislation. Clearly, now is the

time to exercise a little ounce of prevention by starting to curb excessive costs, and this bill does that.

Mrs. LINCOLN. Mr. President, with a mother who is covered by Medicare, I remain committed to protecting seniors' access to Medicare, just as I have throughout my public service, which is exactly why I am opposed to the McCain motion to commit. Mr. MCCAIN's purpose is not to protect Medicare but to frighten our Nation's seniors so that they too will oppose health care reform. I have noted that he has taken his scare tactics to a new level by recording his voice for an automated phone call into my State claiming to seniors that these Medicare savings are going to cut their benefits. He urges them to call me. I believe the seniors in my State know me better than that. They know that I have worked my entire career in this body to protect Medicare.

I have cosponsored the Bennet amendment as an extra safeguard to ensure our seniors that this bill does not cut the guaranteed Medicare benefits that they receive today and that any savings generated from making the Medicare Program more efficient will go back into improvements to the program.

If we do nothing, the Medicare Program will be broke in just 8 years. This bill restores the program's solvency beyond 2022. It will reduce premiums and copays for seniors; ensure seniors can keep their own doctors; cut the billions of dollars of waste, fraud, and abuse that occur annually; provide new prevention and wellness benefits for seniors; lower their prescription drug costs; and help them to stay in their own homes rather than going to nursing homes if that is what they wish to do.

So what about the $500 billion in Medicare cuts Republicans say seniors should be worried about? Well, what they are not saying is that part of the reason Medicare is insolvent is the fact that private insurers under the Medicare Advantage Program are overpaid by 14 percent on average. A typical couple pays $90 more per year in Part B premiums to pay for Medicare Advantage overpayments, even if they are not enrolled in these plans. This bill curbs those overpayments, saving over $118 billion, by for the first time requiring competitive bidding of Medicare Advantage plans against one another. Furthermore, Medicare and Medicaid subsidies to hospitals that help them cover the cost of the uninsured will be reduced since hospitals will have less need for them once millions more Americans have health insurance. That is another $43 billion. Provision after provision is specifically designed to ensure greater value in Medicare, all while the Republicans are using fear tactics to score political points.

I have heard from many seniors in Arkansas, recently, and over the years, about their satisfaction with Medicare. It is not a perfect program, and as a Senator it is my job to ensure that Congress continue to improve upon the program as needed so that it can continue to meet the needs of our Nation's seniors. Rightly so, seniors in my State are concerned about the misinformation spreading that we will cut their benefits and allow bureaucrats to ration their care. Organizations such as AARP, the Alliance for Retired Americans, and the National Committee to Preserve Social Security and Medicare have stood up to say enough with the misinformation campaign. Today I add my voice to that chorus.

Mr. FEINGOLD. Mr. President, I opposed Senator MCCAIN's attempt to send the bill back to committee because it would have effectively ended the current debate on health care reform. Moreover, while I have concerns about some of the offsets in the bill—such as cuts to hospice and home health care—it would be fiscally irresponsible to throw out provisions that cut down on wasteful spending and reward quality, as the McCain motion would have done. Those provisions are key to helping to put Medicare on the path to long-term fiscal sustainability.

The PRESIDING OFFICER. The Senator's time has expired. The next 10 minutes is evenly divided between the Senator from Colorado and the Senator from Arizona.

Mr. MCCAIN. Mr. President, I yield 2 minutes to the Senator from Iowa.

The PRESIDING OFFICER. The senior Senator from Iowa is recognized for 2 minutes.

Mr. GRASSLEY. Mr. President, as I stated earlier, the Bennet amendment, as written, does not protect Medicare. So I have a modification I would like to present that ensures Medicare savings in this bill are not being siphoned off to finance a new and separate entitlement program.

To that end, I ask unanimous consent to modify the amendment by adding the following before the period at the end of subsection (b):

. . . and furthermore that, notwithstanding any other provision of this Act or amendment made by this Act, net Medicare savings specified in the most recent estimate available from the Director of the Congressional Budget Office before enactment are appropriated to the Secretary and shall be used for such purposes and to maintain Medicare policies for home health services, skilled nursing facility services, hospice care, hospital services, and benefits provided by the Medicare Advantage program, as under the provisions of such Title as specified on the day before the date of enactment of this Act.

End of my amendment.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Reserving the right to object, under current law, if less is spent for Medicare providers, the benefits inure to the Medicare trust fund beneficiaries.

Although I have the greatest respect for the Senator from Iowa, this is a stunt, and I object.

The PRESIDING OFFICER. Objection is heard.

Mr. GRASSLEY. Then if I may?

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I would like to make very clear that this objection confirms that the Bennet amendment does not protect Medicare as the other side claims that it protects Medicare.

I yield the floor.

The PRESIDING OFFICER. Who yields time? The Senator from Arizona is recognized.

Mr. MCCAIN. Mr. President, this motion sends the legislation back to the Finance Committee for a short period of time with instructions to report back with cost offsets other than Medicare cuts. The motion says we should retain the provisions in the legislation addressing fraud and abuse and retain those savings to strengthen the Medicare trust fund. Instead of cutting over $450 billion from Medicare providers and beneficiaries, the committee should do what it should have done in the first place—protect seniors' benefits and access to providers. It is much needed.

Mr. President, I say to my friends, let's save seniors who have paid into the Medicare Program their whole lives from these damaging cuts. I hope my colleagues will vote in favor of this motion. Let's use Medicare savings to save Medicare, not to fund a whole new $2.5 trillion entitlement program. I urge a vote in favor of the motion.

I yield back the remainder of my time.

The PRESIDING OFFICER. The Senator from Colorado is recognized for 5 minutes.

Mr. BENNET. Mr. President, I wish to sum up the debate over Medicare in the Senate health bill and on the motion and amendment before us.

Only in Washington, DC, could an effort to extend the life of Medicare somehow be distorted as being bad for seniors. We know from the Congressional Budget Office, a nonpartisan organization that supports both sides of the aisle, that this Senate bill does not take away any seniors' guaranteed Medicare benefits. It extends Medicare solvency for 5 additional years. My amendment simply confirms these two facts.

I am the first person who would insist we have an open process for this debate. I think there are ideas on each side of this debate on this bill that are worth considering and should be considered. But it is why I find it so confounding that opponents of my amendment want to send the entire bill back to committee so debate stops. How can we return home to the people of our States and admit to them we just gave up and sent health care back to the committee for another round?

The people who do not want change are the people who are content to leave it the same and do not have a theory about how to extend Medicare. They would have seniors believe the bill is bad for seniors. Yet AARP, the Alliance for Retired Americans, the Center

for Medicare Rights, and the National Committee to Preserve Social Security and Medicare beg to differ. They disagree. They agree with this amendment and with the underlying bill. Senior advocacy organizations, grassroots organizations with their ears to the ground hearing the voices and concerns of seniors, support health care reform, and they agree that with my amendment, this bill strengthens Medicare and preserves seniors' benefits.

With the Senate bill finally reaching the floor, seniors are looking for simple clarity on how health care reform can help their lives. Nothing in this bill will cut guaranteed Medicare benefits, and this bill will extend Medicare solvency for 5 additional years. It actually makes the system work better instead of cutting or adding to a program. It actually changes the way Medicare works so it will be stronger and more stable.

People may disagree with the prescription, but as a general matter everybody knows the status quo is unsustainable, and this bill helps seniors. It eliminates the copay seniors have to pay for preventive care. We know preventive care saves lives and it saves money.

As we close debate on my amendment and the alternative motion to commit the bill to committee, I urge all the Members of this body to consider the consequences of inaction. My amendment affirms what the current Senate bill does to help seniors and strengthen Medicare. We all know even more can be done, so let's continue this debate and reject the motion to commit the bill back to the Senate committee.

I urge every Member of this body to support my amendment. Please vote yes on the Bennet amendment and protect our seniors.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. BAUCUS. How much time remains?

The PRESIDING OFFICER. The Senator from Montana has 1 minute 50 seconds.

Mr. BAUCUS. The Senator from Arizona has yielded back his time. We might as well yield back our time, and we can vote.

The PRESIDING OFFICER. The Senator from Arizona yielded back his time. The Senator from Montana yields back his time. All time is yielded back.

The question is on agreeing to amendment No. 2826.

Mr. MCCAIN. Mr. President, have the yeas and nays been ordered?

The PRESIDING OFFICER. They have not.

Mr. MCCAIN. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The clerk will call the roll.

The legislative clerk called the roll.

The result was announced—yeas 100, nays 0, as follows:

[Rollcall Vote No. 357 Leg.]

YEAS — 100

Akaka	Enzi	Menendez
Alexander	Feingold	Merkley
Barrasso	Feinstein	Mikulski
Baucus	Franken	Murkowski
Bayh	Gillibrand	Murray
Begich	Graham	Nelson (NE)
Bennet	Grassley	Nelson (FL)
Bennett	Gregg	Pryor
Bingaman	Hagan	Reed
Bond	Harkin	Reid
Boxer	Hatch	Risch
Brown	Hutchison	Roberts
Brownback	Inhofe	Rockefeller
Bunning	Inouye	Sanders
Burr	Isakson	Schumer
Burris	Johanns	Sessions
Byrd	Johnson	Shaheen
Cantwell	Kaufman	Shelby
Cardin	Kerry	Snowe
Carper	Kirk	Specter
Casey	Klobuchar	Stabenow
Chambliss	Kohl	Tester
Coburn	Kyl	Thune
Cochran	Landrieu	Udall (CO)
Collins	Lautenberg	Udall (NM)
Conrad	Leahy	Vitter
Corker	LeMieux	Voinovich
Cornyn	Levin	Warner
Crapo	Lieberman	Webb
DeMint	Lincoln	Whitehouse
Dodd	Lugar	Wicker
Dorgan	McCain	Wyden
Durbin	McCaskill	
Ensign	McConnell	

The PRESIDING OFFICER (Mr. KIRK). On this vote, the yeas are 100, the nays are 0. Under the previous order requiring 60 votes for the adoption of this amendment, the amendment (No. 2826) is agreed to.

Mr. DURBIN. Mr. President, I move to reconsider the vote.

Mrs. BOXER. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

MOTION TO COMMIT

The PRESIDING OFFICER. There will now be 2 minutes of debate equally divided on the motion to commit offered by the Senator from Arizona.

The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I ask my colleague if he wishes to go first? Whatever he wants to do. It is his motion.

Mr. MCCAIN. Please go ahead.

Mr. BAUCUS. Mr. President, the McCain motion is next. Unless we act today and pass health care reform, the Medicare trust fund runs out of money in 2017. There are two ways to keep Medicare solvent: find efficiencies so Medicare spends less or increase revenues going into the trust fund—two ideas. Our bill would make Medicare Advantage more efficient. We would introduce competitive bidding——

Mr. BYRD. Mr. President, may we have order? We have a Senator speaking here. May we have order?

I thank the Chair.

Mr. BAUCUS. I thank the Senator from West Virginia.

We extend the trust fund for 5 more years. That is in this bill. Yes, Medicare Advantage plans would not be overpaid as much, but those plans could pay for greater efficiency by cutting their profits or cutting their executives' pay. They could do that. Nothing says they have to go after beneficiaries.

Our bill does nothing to reduce the guaranteed Medicare benefits. To the contrary, our bill would improve Medicare benefits. It would help seniors on the prescription drug doughnut hole and add new preventive benefits such as annual wellness visits. The bill would help ensure doctors would be available to treat Medicare patients. We would prevent the 21-percent cut in doctor payments under current law. For all those reasons, the American Association of Retired Persons supports reform and opposes the McCain motion.

I urge my colleagues to support reform and oppose the motion to commit.

Mr. MCCAIN. Mr. President, this motion proposes to send the legislation back to the Finance Committee to remove the nearly $½ trillion in cuts that will severely impact all seniors who are eligible for Medicare. As the Senator from Montana mentioned, the system is going to go broke in 7 years. So what does this legislation contemplate? That we take $½ trillion out of their savings and use it to fund a $2.5 trillion new entitlement program. What does that do for the Medicare trust fund? Nothing.

I urge my colleagues to vote in favor of this motion and send it back to the Finance Committee. Do the right thing for the seniors of this country.

Mr. BOND. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The question is on agreeing to the motion. The clerk will call the roll.

The assistant legislative clerk called the roll.

The result was announced—yeas 42, nays 58, as follows:

[Rollcall Vote No. 358 Leg.]

YEAS—42

Alexander	DeMint	McCain
Barrasso	Ensign	McConnell
Bennett	Enzi	Murkowski
Bond	Graham	Nelson (NE)
Brownback	Grassley	Risch
Bunning	Gregg	Roberts
Burr	Hatch	Sessions
Chambliss	Hutchison	Shelby
Coburn	Inhofe	Snowe
Cochran	Isakson	Thune
Collins	Johanns	Vitter
Corker	Kyl	Voinovich
Cornyn	LeMieux	Webb
Crapo	Lugar	Wicker

NAYS—58

Akaka	Franken	Mikulski
Baucus	Gillibrand	Murray
Bayh	Hagan	Nelson (FL)
Begich	Harkin	Pryor
Bennet	Inouye	Reed
Bingaman	Johnson	Reid
Boxer	Kaufman	Rockefeller
Brown	Kerry	Sanders
Burris	Kirk	Schumer
Byrd	Klobuchar	Shaheen
Cantwell	Kohl	Specter
Cardin	Landrieu	Stabenow
Carper	Lautenberg	Tester
Casey	Leahy	Udall (CO)
Conrad	Levin	Udall (NM)
Dodd	Lieberman	Warner
Dorgan	Lincoln	Whitehouse
Durbin	McCaskill	Wyden
Feingold	Menendez	
Feinstein	Merkley	

The PRESIDING OFFICER. On this vote, the yeas are 42, the nays are 58.

Under the previous order requiring 60 votes for the adoption of this motion, the motion is withdrawn.

Mr. BAUCUS. Mr. President, I move to reconsider the vote.

Mr. HARKIN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The majority leader.

Mr. REID. Mr. President, I ask unanimous consent that the Senate be in a period of debate only between now and 4:30. It is my understanding there has been an agreement that at 4:30 we will all go to the classified room in the Visitor Center to listen to what the administration has to say about Iraq and Afghanistan. I haven't had a chance to clear this with the Republican leader, but for the next hour we will remain in a period of debate only and come back and offer the amendment after we finish with the classified briefing.

We have not yet had agreement to recess at 4:30. I ask unanimous consent that we recess from 4:30 until 5:30 for a classified briefing.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Idaho.

Mr. CRAPO. Mr. President, I wish to continue discussing the health care legislation we just voted on. We had a series of votes dealing with the Medicare issue. I wish to start my remarks by turning to the Senator from Mississippi, Mr. WICKER, and ask him if he has comments he wishes to make.

Mr. WICKER. Mr. President, I appreciate the Senator yielding to me. I think it is important for us all to understand where we are now. We have had a debate about the Medicare issue. The Senate had an opportunity, with the McCain amendment, to protect Medicare from the almost one-half trillion dollars in cuts the Reid bill proposes to do to Medicare. We said no to that opportunity and instead passed the amendment offered by Senator BENNET of Colorado which in sum total does absolutely nothing. What we have done now with the Bennet amendment is say that along with apple pie and motherhood, we also love Medicare, and we want everybody to know that. But the substantive effect of what we have now done is nothing.

I have this challenge to the managers of the bill on the other side and to the Democratic leadership: Now that Bennet has passed and McCain has been defeated, I challenge them to take this bill, send it back to CBO and CMS and have the independent analysts there look at it again. They will be duty bound to come back with the facts. The facts will be that the almost one-half trillion dollars cut in Medicare is still there.

Now that the McCain motion to commit has been defeated, and the sham of the Bennet amendment has been passed, there are still the same cuts to hospitals, there are still the same cuts to Medicare Advantage and to all the senior citizens who depend on that and who were told during the campaign their coverage would not be taken away from them if they liked it. The cuts to nursing homes are there. The cuts to home health are there. And the cuts to hospice are still there.

Send the bill back to CBO. We can continue debating it. We will not have to miss out on one bit of rhetoric that we have already had. But ask the independent analysts: Are the Medicare cuts still there? They will be duty bound to come back to us and say: Yes, the same cuts that were there before are current in the bill now.

We have accomplished absolutely nothing today to protect Medicare.

I thank the Senator for yielding.

Mr. CRAPO. Mr. President, I thank the Senator from Mississippi.

Mr. President, I ask unanimous consent that several of my colleagues and I may engage in a colloquy during the time we have.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. CRAPO. Thank you, Mr. President.

I wish to follow up on the comments of Senator WICKER from Mississippi because it is very critical that the American public understand what has happened in the Senate.

When you talk about health care reform, the vast majority of Americans have a couple of ideas in mind. First and foremost, they want to lower health care premiums and costs. That is what Americans think about primarily when they think about the need for health care reform.

They also want to see better access to quality health care and make sure those who are uninsured have access to health care, and those who are underinsured have access to health care, and that we all have access to quality health care. That is what this debate should be about.

But, instead, the legislation we see before us does not achieve that. Does it reduce the cost of health care? No. It drives up the cost of health care. It raises taxes hundreds of billions of dollars. It cuts Medicare by hundreds of billions of dollars. It grows government by $2.5 trillion of new spending. It forces the most needy in our society into a failing Medicaid system. It imposes a damaging unfunded mandate on our struggling States. It still leaves millions of Americans uninsured and establishes massive government controls over our health care economy, including the creation now of a government insurance company.

We have been focusing in the debate on one part of this for the last little while; that is, the Medicare cuts. Mr. President, $464 billion of the revenue to pay for this massive new entitlement that is being created is to come from Medicare, and it is nothing other than a direct transfer of assets in the United States from America's seniors in the Medicare system to a new government entitlement program.

There are other cuts. There are details of these cuts that I will put up right now on a chart.

The debate we have been having over the last, oh, almost 3 or 4 days now, is whether we should commit the bill back to the Finance Committee so these Medicare cuts can be removed. We just had two votes. One was what I will call a cover vote. It said we do not want to cut Medicare benefits and we should make sure that anything we do protects Medicare. It did not have any detail in it, but it passed 100 to nothing because it does nothing. It does not change what is in the bill. By the way, as I said, that vote just passed by 100 to nothing.

The second vote we took failed. Was the vote 40 to 60? I do not recall the exact vote. What would that amendment have done? That amendment would have put the bill back into the Finance Committee and required that we take out the Medicare cuts.

So let no one be confused, after the first round now in the Senate, we still see this in the bill—a transfer of $464 billion from the Medicare Program to the establishment of a new entitlement program. I do not believe that is what Americans had in mind when they were talking about reform of health care.

There has been a study that came out—OK. I have the exact vote here. It was not 40 to 60. It was 42 to 58, but it was defeated, in any event, and now we still have the cuts to Medicare in the bill. Well, we are going to continue debating this issue.

I myself have an amendment that will send—for the skilled nursing homes—the bill back to Finance to correct the cuts for the skilled nursing homes. There are others who will try to address some of the pieces of this legislation to see if we can't find a way to fix and restore the strength and stability of the Medicare system.

Everyone admits we need to reform Medicare. But until this bill, none of us thought we were talking about taking from Medicare in order to create a massive new entitlement program, with the government control that comes along with it.

What do these cuts do? I am going to start out with the hospitals, the hospice services, the nursing homes, and the home health agencies. The reduction in Medicare spending on these medical providers will basically result in lower access to care for our seniors. I have had representatives in my office of both skilled nursing facilities and home health agencies who have talked to me about what this means to them. They have pointed out that the last time Congress did something like this, we lost, in Idaho, 30 percent, for example, I believe it is, of our home health agencies. They are not there anymore. If we have these kinds of deep cuts in the future, we are going to lose more of our home health care agencies.

One of the owners said to me—he put it this way: If you reduce the allocation of income to home health agencies, I have to either reduce employment, which means not hire as many nurses and medical providers, or I have to close parts of my building and stop operating as many rooms in the building, or do something to reduce costs.

What that means is that seniors will have less access. But that is not all this bill does. In addition to reducing the access for hospitals, hospice service, nursing homes, and home health agencies, it also cuts Medicare Advantage deeply.

Quickly, what is Medicare Advantage? Medicare Advantage is a program that about one out of four American seniors participate in in Medicare. It is an opportunity which Congress started a few years back to try to let the private sector become a part of the delivery system in Medicare. In other words, to put it simply, private sector insurance companies can contract with the Federal Government to provide Medicare services to Medicare beneficiaries, so it is the private sector getting involved in health care delivery rather than the government simply delivering the health care through a single-payer system. That, in a quick summary, is what Medicare Advantage was all about.

What we found was that it was phenomenally successful because the private sector was able, through its management, to not only provide the statutorily required Medicare coverage but additional benefits, very critical additional benefits, such as preventive health care, dental coverage, vision coverage, and things such as that—things that make a big difference in the lives of our seniors and enables some of those who cannot buy additional coverage for those things Medicare does not cover to get access to it through Medicare Advantage.

That is why in my State 27 percent of all of the Medicare recipients have moved to Medicare Advantage. It is the most popular part of Medicare in America today, and it is growing faster than any other part of Medicare because it is delivering more to the Medicare beneficiaries.

This bill slashes $120 billion from it, some of us believe because there is a bias against the private sector delivery of health care. But for whatever reason, the Medicare Advantage portion is where the cuts are focused.

Let's put up the next chart.

When we had the issue before the Finance Committee, we had the head of CBO before us, and I asked him a question about the cuts to Medicare Advantage. We had a colloquy between us at that point, and I asked:

So, approximately half of this additional benefit—

In other words, these additional things that Medicare Advantage has been able to provide to our seniors under Medicare—

So, approximately half of this additional benefit would be lost to those current Medicare Advantage policyholders?

And his response was:

For those who would be enrolled otherwise under the current law, yes.

The point being, not only will we lose skilled nursing facilities, home health care, hospice care, and hospital care, and access to that care, we are also going to see senior citizens lose benefits. Again, what is the purpose? The purpose is not to shore up Medicare. In fact, it will take $464 billion—taxpayer dollars that are allocated to Medicare in our current system—and transfer that straight over to the establishment of a new entitlement program.

I want to let my colleague from Nevada comment on this for a minute, but before I turn it over to my colleague from Nevada, I wish to point out that as we approach this issue, the question of why would we transfer $464 billion out of the Medicare system to a new government entitlement program, one of the reasons is because the President pledged he would not sign a bill that did not reduce the deficit.

As I said earlier, this bill grows the spending in the Federal Government by approximately $2.5 trillion over the first full 10 years of its implementation of spending. The only way to cover that increase in the size of the government is to either raise more taxes or to cut spending somewhere, and what the bill does is both. It raises taxes—which we are going to be talking about in future days—and it cuts spending. The place where it cuts spending is Medicare. That is why what we see is increased taxes, cuts in Medicare, growth of government, and the establishment of a new Federal entitlement program, with all of the accompanying accoutrements of Federal control, including a new government owned and operated insurance company.

I see my colleague from Nevada standing and turn to him for his comments on this issue.

Mr. ENSIGN. First of all, I think my colleague from Idaho has made some excellent points about, truly there will be cuts that are going to happen in Medicare. And do not just take the politicians' word for these cuts. Listen to the CBO Director. He is the nonpartisan, I repeat, nonpartisan, official scorekeeper. When asked direct questions, by not only the Senator from Idaho but others, he absolutely says the benefits, especially under Medicare Advantage, will be cut.

In my home State of Nevada, tens of thousands—I think about 200,000 altogether—of seniors have voluntarily chosen Medicare Advantage over traditional Medicare. The reason? Very simple. There are extra benefits in Medicare Advantage. You hear the Democrats talk about the doughnut hole in Medicare Part D, which is prescription drug coverage. Well, there is not a doughnut hole under most of the Medicare Advantage plans because the private sector, through its efficiency, has been able to fill that doughnut hole. In other words, they get complete coverage of prescription drugs through their Medicare Advantage plans.

Also, under Medicare Advantage, they get additional preventive health care services. They also get vision and dental. And depending on the plan, depending on its makeup, there are different types of benefits to attract seniors to certain plans. It is no wonder that about one out of four seniors in America have voluntarily signed up for Medicare Advantage. Nobody forced them into this system. They voluntarily chose this system.

If you think about it, seniors do not like change. For most seniors, they like what they have. They do not like to change. For one out of four seniors to have voluntarily changed, there has to be something pretty attractive about Medicare Advantage.

There are some real attractive things for seniors in Medicare Advantage plans. That is why when you actually poll seniors regarding Medicare Advantage, the vast majority of them are thrilled with the coverage they have. They do not want to lose benefits. Who would want to voluntarily lose benefits?

But with the $120 billion cut in Medicare Advantage the Democratic majority has put in this bill, about half of the benefits in Medicare Advantage plans will be cut. Isn't that correct, I ask my friend, the Senator from the State of Idaho?

Mr. CRAPO. The Senator from Nevada is correct. In fact, I am just thumbing through here to get the exact statistics. But the bottom line is, the CBO indicated, I think it was something like from an average number of $140 or so of extra benefits—that it would go down to about half of that. So they would get about half of those extra benefits.

Mr. ENSIGN. That is per month?

Mr. CRAPO. Per month.

Mr. ENSIGN. So $140 per month. According to CBO, about half of those benefits would be cut under this plan, isn't that correct?

Mr. CRAPO. That is correct.

Mr. WICKER. If the Senator would yield on that point.

Mr. CRAPO. I would be happy to yield.

Mr. WICKER. We have three Republicans standing now saying this, and we have had quoted some official independent sources. Let me quote a Democrat, Representative MICHAEL MCMAHON of New York:

Medicare Advantage, which serves approximately 40 percent of my seniors on Medicare, would be cut dramatically.

That is why that Democrat from the State of New York voted no on the plan when it was before the House of Representatives. So you don't have to take our word for it, from a partisan standpoint. Democrats are saying no because of the Medicare cuts and the cuts to Medicare Advantage—drastic cuts.

Mr. ENSIGN. The Senator from Idaho and I serve on the Finance Committee

where a large portion of this bill was written. We both heard Democrats on the other side of the aisle complaining about cuts to Medicare Advantage. Yet when I look in this bill, the total dollar figure in cuts to Medicare Advantage is the same as what came out of the Finance Committee; isn't that correct?

Mr. CRAPO. The Senator from Nevada is correct. I have in front of me the exact numbers right now from CBO that were provided in the Finance Committee markup. During the markup, CBO estimated that the value of the extra benefits offered by Medicare Advantage plans will drop from $135 a month to $42 a month, based on the cuts contained in that bill, which are essentially the same level of cuts we now see in the bill before us on the floor.

Mr. ENSIGN. Let me make a couple other general points about this bill. I think we have pretty well covered the fact that Medicare Advantage is going to take a severe hit. Medicare overall, that includes hospice care, hospital care, nursing home care, home health—all of them are taking severe cuts. More than likely, those cuts are going to come, if the government doesn't rescue those cuts in the future, from benefits to seniors.

If the government decides not to have those cuts in the future, then the deficit is going to go up. You can't have it both ways. You can't have both a deficit-neutral bill and not have the cuts in Medicare. In other words, you are going to either have the cuts in Medicare or you are going to have ballooning deficits into the future.

There are several other problems with the bill that I would like to point out. First of all, we know it is over 2,000 pages; there is incredibly complex language in those over 2,074 pages. It places bureaucrats in charge of health care decisions instead of creating a patient-centered health care system that says the doctor-patient relationship is where most of the health care choices should be made. As a matter of fact, according to the National Center for Policy Analysis, in almost 1,700 places in this bill it authorizes the Secretary of Health and Human Services to ''make, create, determine, or define'' things regarding health care policy. Mr. President, 1,697 times, to be exact, the Secretary of Health and Human Services basically makes health care policy—not doctors, not health care providers; bureaucrats in Washington, DC.

You mentioned before there were $½ trillion in new taxes and about $½ trillion in Medicare cuts. We know this bill will lead to millions of Americans having increased premiums.

We have talked a lot about what is wrong with the bill, however, many on this side of the aisle have offered positive solutions. We have talked about allowing small businesses to join together to take advantage of purchasing power that big businesses have. We have talked about allowing people to buy insurance across State lines. Some States have less expensive plans than others. You can buy your auto insurance across State lines. Why shouldn't we be able to buy our health insurance across State lines?

Mr. CRAPO. If I could interrupt, my understanding is, the Republican bill in the House, which has both ideas in it and which was evaluated, what it would do to the cost of health care and health care insurance premiums, that those ideas would actually reduce health care premiums by, I think, 5 or 6 or 8 percent. I don't remember the exact number, but the point is, those ideas would hit the reason Americans want health care reform; that is, reduce the cost of health care coverage.

Mr. ENSIGN. I am glad the Senator from Idaho made that point, because the No. 1 problem with health care in the United States is not quality. We have the finest quality system—by almost any measure, the finest quality health care system in the entire world. The problem is that it is too expensive. We should be going after costs. This bill does not do that. This bill actually raises premiums for tens of millions of Americans. That isn't the direction we should be taking health care.

Another idea the vast majority of people on this side have supported is medical liability reform. Once again, in the Finance Committee, we asked the question—I, personally, asked the question of the CBO Director: How much money would medical liability reform—the common one I offered and Senator HATCH offered—how much would that save between the government and the private sector? He said: Over $100 billion. Well, that is not chump change; that is a significant amount of money, $100 billion. Add that to buying across State lines, add that to small business health plans, add that to incentivizing healthy behaviors—add that to the elimination of preexisting conditions. I think Republicans and Democrats alike agree, if you have insurance and you have played by the rules and you get a disease, your insurance should not be taken away or denied. We should eliminate preexisting conditions for those that have played by the rules. We shouldn't allow insurance companies to unexplainably increase rates. We should take a step-by-step, incremental approach to health care reform instead of gutting Medicare, as the Senator from Idaho has talked about, to create a new government entitlement program. That is what we are saying on this side of the aisle. However, it seems to be falling on deaf ears on the other side of the aisle.

Mr. CRAPO. I know my colleague from Mississippi wants to make a comment or two, but may I ask, Mr. President, how much time remains for our side?

The PRESIDING OFFICER. There is 7½ minutes.

Mr. WICKER. Mr. President, if I could just maybe take 1 minute of that time and then y colleagues can wrap it up.

I wish to emphasize what a devastating effect these Medicare cuts are going to have on rural America. Once again, I wish to quote some of my colleagues from the other end of the building because it shows the bipartisan opposition we have against these cuts from rural America.

MIKE ROSS, a Democrat from Arkansas, said:

> With more than $400 billion in cuts to Medicare, it could force many of our rural hospitals to close, providing less access and care for our senior citizens.

Representative LARRY KISSELL of North Carolina:

> From the day I announced my candidacy for this office, I promised to protect Medicare.

So he voted no on the bill in the House of Representatives.

IKE SKELTON said:

> The proposed reductions to Medicare could further squeeze the budgets of our rural health care providers.

Finally, Representative BOUCHER, a senior Democrat from Virginia, said:

> The plan could place at risk the survival of our regions' hospitals.

Unless these Medicare changes are taken out of the bill, this bill devastates health care for senior citizens in rural America.

I thank my colleague for yielding me the time.

Mr. CRAPO. Thank you very much. I wish to use the remainder of our time to speak for a minute about what this bill does to different costs in our country. I think the point we made in this colloquy is, after the votes we just took, let no one be confused; the $464 billion of cuts to Medicare remain in the bill.

Let's talk about the question of the cost curve. There has been a lot of talk about what has become known as the cost curve. It has been said by everybody we need to bend the cost curve down. Some are saying this bill bends the cost curve down. Well, which cost curve are they talking about? Are they talking about the size of government, the growth of government? No. If you take the first full 10 years of the growth of spending in this bill—which, by the way, is delayed for 4 years—if you start when the spending starts and take the first full year, 10 years of spending, the new spending, the growth of government is about $2.5 trillion. I don't see how anybody could say that cost curve is bending down. It has skyrocketed.

Well, would it be the cost of health care, which I think is the cost curve Americans were thinking about, health care insurance and the quality of health care that is provided? Well, CBO just came out with its report that analyzed that issue and there are a number of independent groups that have analyzed it and they all pretty much say it is not going to reduce the cost of health insurance. It is not going to reduce the cost of health care. In fact, for

the neediest in America, those who are in the individual market, it will drive up the cost of their insurance and not by just a little bit, by around 10 to 13 percent. For those in the small group area, it will drive up theirs—not as much—by about 1 to 3 percent. For those in the large group area, there is a possibility that theirs might taper off a little bit; the estimate is somewhere between zero impact and 2 percent reduction.

But is that what we are talking about in America, 30 percent of the people in this country seeing their health care insurance costs go up and the rest seeing theirs remain basically stable? That is not the cost curve reduction I thought Americans were talking about in health care reform.

So then what other cost curve could they be talking about? Well, there is a lot of talk about the deficit. Sometimes they try to shift away from the cost of health care to the cost of the bill to the people of America, and they say the deficit is reduced. Well, how can you say that? There is only one way you can say that and that is if you accept the budget gimmicks in the bill. If you raise taxes by around $500 billion and if you cut Medicare by $464 billion, then you can say this massive expansion of government is somehow covered and that the deficit won't grow.

Well, I think we have talked about the Medicare cuts part of this. We are going to talk about the tax increases, which are hundreds of billions of dollars of new taxes in the future, but what did I mean when I said you can only say the deficit goes down if you accept the budget gimmicks?

This bill starts the collection of revenues and the cuts out at the front end but doesn't start the spending for 4 years, so you have 10 years—in the 10-year window we are looking at, we have 10 years of revenue and 6 years, basically, of spending. Sure, if you only count 6 years of the spending side of the bill against 10 years of its collection side, you are going to be able to make that deficit look a little better.

In addition, there are major expenditures we all know are going to have to be done in health care, such as the SGR fix for physician compensation in Medicare, that are not even in the bill, an expense we know over 10 years is around 200 billion to 250 billion of extra dollars; simply not there, not counted. Well, if you want to show a deficit reduction, you certainly want to leave out of your bill a lot of the spending you are going to do in the future. It is gimmicks such as these, it is tax increases, and it is Medicare cuts that allow one to say the deficit goes down.

In conclusion, the reality is, this bill will increase the growth of government by $2.5 trillion for a full 10-year measure, increase taxes by hundreds of billions of dollars, cut Medicare by hundreds of billions of dollars, create a Federal insurance company, create massive Federal controls over the health care economy, push the neediest of the uninsured not into an insurance policy but into a failing Medicare system, and push an unfunded mandate of tens of billions of dollars onto our States. That is not the kind of health care reform we need. As my colleague from Nevada indicated, there are reforms that do make a difference that will reduce the cost of health care, that will cut down the spiraling costs of health care insurance, and will not require us to have such an intrusion of the Federal Government into the management of our economy.

It is time for us to slow down and start, step by step, to address the kinds of reforms that will reduce the cost of insurance and the cost of health care and that will help us to increase access to quality care in America. We can do it, and we have a number of very good ideas on the table we will be exploring in greater detail in future days as well that will help us to do it.

With that, I reserve the balance of our time.

May I ask how much time remains?

The PRESIDING OFFICER (Mrs. SHAHEEN). The minority has no time.

Mr. CRAPO. I thank the Chair.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Madam President, I think it would be instructive to stop all this rhetorical talking past each other on Medicare Advantage and explain a little bit about how we got to where we are in this legislation.

I don't know the exact year, but I think it was back in the 1980s sometime, up to a certain point Medicare was basically paid fees for services. That is the basic Medicare model. The service was provided and there are certain set rates for that service. Then, in the 1980s, private companies thought maybe they could be more efficient, private insurance companies. So they came to Congress and said: We can do a better job in compensating Medicare based on fee for service, so let's set up something called Medicare Advantage, private entities.

So Congress said: OK, competition is a good thing. So we did that. Congress did that. We basically set the rates to be paid to Medicare Advantage plans at 95 percent of fee for service. After all, the plan said they could do it more cheaply and they could compete. So we said: OK, that sounds like a good idea. We will pay you 95 percent of what otherwise would be paid under fee for service. That continued for a while.

In 1997, the plan said: Gee, we need a little more money. So Congress said: All right. And we gave a little more money to Medicare Advantage and basically said, OK, that will pay the 95 percent. But if you are not doing so well and making money at 95, we will set kind of a higher floor, according to certain areas of the country, and you could choose whatever enables you to have the greatest compensation.

The big change occurred in 2003, in the Medicare Modernization Act, otherwise known as the drug bill. It was the legislation that created drug benefits for seniors. As we all know, frankly, when Medicare was created, it didn't have an outpatient drug benefit because drugs weren't comparatively as important then as they are today. Today there are miracle drugs that help in a lot of ways. We created the drug benefit in 2003.

The Congress did something else then. Many Members of Congress were concerned that Medicare Advantage might not offer the plans in rural parts of America, that there wouldn't be enough incentive for Medicare Advantage to go to rural America to offer the drug benefits—not only the drug benefits but other benefits they provided. Congress, frankly, gave a lot of money to Medicare Advantage plans so there could be at least two plans operating in all parts of the country. Give them enough money and they will go; that was the theory. Guess what happened. We gave them a lot of money and they went.

We have reached the point now where Medicare Advantage is, by everybody's estimate, quite dramatically overpaid, as the Senator from Oklahoma, Mr. COBURN, said when I asked him yesterday whether Medicare Advantage plans are overpaid. He said, ''Yes, they are definitely overpaid.''

MedPAC, which advises us on Medicare reimbursement, said to us that we are way overpaying Medicare Advantage plans. I hear figures of from 14 to 18 percent overpayment. It depends on what part of the country you are in. Let's be conservative and say it is 14 percent in fee for service, that they are overpaid. MedPAC is an independent advisory group that helps us figure out what in the world we pay hospitals, nursing homes, home health agencies, etc. We are not the experts. We need help. MedPAC said to the Congress that we are overpaying them big time.

We decided let's figure out a way to reform the system. How about a little competition? Right now, Medicare Advantage plans are paid what is called a benchmark, depending upon the fee for service in their certain area. We all know fee for service is much less in rural America, and I am sure in the home State of the occupant of the chair. Fee for service is much higher in other more urban States and so forth.

As it turned out, under the benchmarks for fee for service, they were way overpaying in States where fee for service is so high, and not quite as much overpaid where fee for service is so low. That is a nutty system in the current law today.

What we are doing in this legislation is, basically, we are saying: Look, let's introduce a little competition. We are saying: Let's get rid of the benchmark-type fee for service. It is out of whack in different parts of the country. What are we going to do? We say: OK, we will divide the country into geographic areas. In your area, wherever you might be, Uncle Sam—or Medicare—will pay the average competitive bid

for that area. The average cost you bid for that area is what we are going to pay, which eliminates this big disparity between States and makes it much more fair so that reimbursement is based much more on what it actually costs in a certain area, but it is competitively bid. That is what we are trying to do.

Is that a good thing to do? I think most of us think so. Is it perfect? I don't know for sure, but we are trying our best to make this a better system, a better program than we currently have. As a consequence, we are going to save some money, and there will be competition. Most of us think competition is often a pretty good thing. That is what this is, I remind my colleagues. As a consequence, we are not going to be overpaying Medicare Advantage plans anymore. The amount we reduced the payment to is in line with what MedPAC says we should pay, the Medicare Payment Advisory Commission.

We are trying to be responsible and reasonable with taxpayer money, seniors who pay into Medicare. The point is often made that, gee, this will hurt Medicare Advantage, hospitals, and so forth. I think it is worth reminding all of us that a meeting occurred at the White House, I think, 4 to 6 months ago, when all of the so-called providers—the hospitals, insurance companies, including Medicare Advantage plans—all got together with the President and said: Mr. President, we agree this country needs health care reform. They all agreed.

Let's move back in history a little bit. When President Clinton attempted health care reform, all those groups were opposed to health care reform. This time, they are pretty much in favor of it because they know if we don't fix it, it is going to collapse.

Back to that meeting. What did they say? They said: Mr. President, we have all gotten together and we think we can contribute. We can cut collectively $2 trillion in payments that go to us over the next 10 years.

That is what they said. That is pretty interesting. Thank you very much. So we are working together to get health care reform.

Why do you think they would agree to $2 trillion? They got their calculators out and got their financial officers together and said: Gee, if everybody has health care—remember, 46 million Americans don't have health insurance—if everybody had health insurance, hospitals, Medicare Advantage plans said: Hey, we can make some money because everybody has health insurance.

So that was the deal. They will have a little lower margins, but they will make it up on volume. That is why they said to the President: We can cut $2 trillion that otherwise would be reimbursements to us.

In this legislation, did we reduce the rate of increase over 10 years by $2 trillion? No. Did we decrease the rate of increase in expenditures by half of that or $1 trillion? No. Do we reduce the rate of increase of health care expenditures down to, say, $450 billion, close to $500 billion? Yes, that is what we did. About one-quarter of the industry said they could voluntarily contribute. Are they squawking today? No. Why? Because they got a pretty good deal. They know they can continue to provide services and the hospitals are going to do well and home health care agencies will do well. I will add that the profit margin for home health agencies is about 17 percent. That is pretty good. So we are cutting them a little bit. The profit margin for nursing homes—Medicare payments to nursing homes—is about 15 percent. We are cutting that a little bit. But they are still making money and still will do well. In fact, their average rate of growth over the next 10 years is going to be in excess of 5 percent a year. Wall Street analysts say these outfits are doing pretty well. You don't see their stocks going down.

We are trying to do what is right and to reform Medicare Advantage, as I just outlined it. It is a pretty fair attempt at reform. Also, we will reduce payments to hospitals and other providers in an amount that they can live with—not be happy with but an amount they are OK with, and where they know they can still make money. That extends the solvency of the Medicare trust fund another 5 years because those providers are not being paid as much as they would otherwise be paid.

I hear Senators crying crocodile tears about how seniors are going to be cut, and so forth. Frankly, with the changes we made, I think it is very fair, and it will extend the solvency of the trust fund. There is not one dime of guaranteed Medicare benefits that will be cut—not one thin dime—in this legislation. It is true that because Medicare Advantage—the rate of growth of increase in Medicare Advantage plans is trimmed back a little, perhaps there will not be as many extra benefits—not the guaranteed benefits but extras, fringe benefits, like gym memberships and things like that. Don't forget, that is not because that is a decision made by Medicare or by Congress; that is a decision made by the executive offices of these private companies. I am not saying they should do this. They could trim salaries, overhead, and they could have a little less return to stockholders, and they could cut down administrative costs. There are various things they could do, which doesn't have to be passed on to reductions in fringes. Let's keep things in perspective as to what is actually going on.

Mr. DODD. If my colleague will yield, I appreciate what the Senator has just done. This is an area where I think there is a lot of confusion and misunderstanding. A lot of it begins with just the branding, the title of something. This was, frankly, a revelation to me, going back a number of weeks ago. I heard the words ''Medicare Advantage.'' I thought this has to be part of the regular Medicare Program because it has that title.

Mr. BAUCUS. Most people did.

Mr. DODD. If my colleague will correct me if I am wrong, this is not traditional Medicare; this is a private plan, right?

Mr. BAUCUS. That is correct. To be totally fair, the other side likes to trot out this Medicare pamphlet that includes Medicare Advantage. I think that is misleading and not accurate. As the Senator says, these are private plans.

Mr. DODD. In looking back a few years ago, the original reason—and I don't recall the debate as well as my colleague, the chairman of the Finance Committee, does. As I remember, the original idea behind this was—and he said this already, but it deserves being repeated—this was a way of cutting costs, reducing expenditures. In a sense, we were sold this idea on the fact that we could do this better, more efficiently, at far less cost.

Mr. BAUCUS. Absolutely. That was the rationale.

Mr. DODD. That is why we supported trying this idea. A couple of things happened since then. One, I think the overpayments, on average, are around 14 percent.

Mr. BAUCUS. That is correct. It depends on the part of the country.

Mr. DODD. So, on average, it is 14 percent in overpayment. Is it also true that roughly 80 percent of Medicare beneficiaries don't get any of these benefits?

Mr. BAUCUS. That is correct.

Mr. DODD. And that the average Medicare couple over the age of 65 is paying, I am told, about $90 a year more in Medicare payments for benefits they don't get.

Mr. BAUCUS. Exactly.

Mr. DODD. So here we have 75 to 80 percent of the beneficiaries of Medicare paying more money and not getting the benefits for a program that costs more than 14 percent more, and it is a private plan.

Mr. BAUCUS. With great considerable administrative costs and profits that otherwise could go to seniors.

Mr. DODD. Our bill does something that I think our friend from Oklahoma, Senator COBURN, pointed out that is absolutely critical, which is that competitive bidding did not exist in the original.

Who was setting these rates originally during this period of time? How did these rates get set? Did Congress set them?

Mr. BAUCUS. Congress did. Congress set the benchmarks.

Mr. DODD. Is it true that if these Medicare Advantage plans come in under the benchmark bid, they actually get a piece of the savings? Is that correct as well?

Mr. BAUCUS. That is correct.

Mr. DODD. So there is an incentive to trim the cost of the administration of the program. It is also true the plans get bonus payments for care, coordination, and quality, and plans can use these bonuses to improve benefits?

Mr. BAUCUS. That is correct. Under this legislation, we say—frankly, under the earlier Medicare Advantage plans, HMOs had some coordinated care, but the other half, the private fee for service, preferred provider organizations did not have coordinated care.

We are saying in the legislation that if you are in the Medicare Advantage plan, which includes a whole list, and you provide coordinated care, we are going to give you a bonus.

Mr. WICKER. Madam President, will my friend yield for a question?

Mr. DODD. Certainly.

Mr. WICKER. I realize we do not have much time. I have a quick question. I was listening to the debate on television. I understood the Senator to say Medicare Advantage is not part of Medicare. My question is: I have here the Medicare handbook for 2010, ''Medicare and You.'' It says right on page 50:

Medicare Advantage Plans (Part C). A Medicare Advantage plan . . . is another health coverage choice you may have as part of Medicare.

My question to the Senator is—to my friends on the other side of the aisle: Is the Medicare handbook inaccurate and, if so, will you be calling CMS, Medicare, and be asking them to change what they say explicitly on page 50 of the Medicare handbook?

Mr. BAUCUS. That is a very interesting question. When I was told about the handbook, that is what I thought I was going to do, is call up Medicare and say that is misleading and it is inaccurate because it is misleading and it is inaccurate.

Mr. DODD. Absolutely.

Mr. BAUCUS. These are private companies.

Mr. WICKER. Even though Medicare put it in their handbook, has had it for several years, it is wrong?

Mr. DODD. They are wrong. It is a private health care plan. It is a private health care plan. Medicare is a public plan. Medicare Advantage is not Medicare, and it is certainly not an advantage, given the overpayments that occurred.

Mr. WICKER. Isn't it in part of the Medicare legislation?

Mr. DODD. It is a private plan. My colleague understands that, I hope. Medicare Advantage is a private plan. You know that, of course, don't you? I assume you know that.

Mr. BAUCUS. It has officers, a board of directors.

Mr. WICKER. I know this. It is in the handbook. I want my two friends of the majority party to get it out of there. We thought all along it is part of Medicare and the millions of senior citizens who rely on this and who were told in the campaign, if you are satisfied with your coverage, you don't have a thing to worry about, they are going to be able to keep their coverage. Under the Democratic legislation, they would not be allowed to keep their coverage under this bill.

Mr. DODD. If I can reclaim my time, 80 percent of older Americans are paying $90 more a year for this. Do they have any say in this? They don't get any of the benefits. Why are they writing a check for $90 a year to pay a private plan from which they get no benefits? What about them? Don't they deserve something in all this?

Mr. WICKER. The question I had was: Is this a part of Medicare?

Mr. DODD. It is not.

Mr. WICKER. I realize my friends have a difference of opinion. The authorities for Medicare who put this publication out year after year say Medicare Advantage is part of Medicare. It is Part C. I think it is disingenuous for my friends to say it is not.

Mr. DODD. The only reason it is part of it is it is subsidized. This plan gets subsidized by the American taxpayers. That is the only qualification that puts it under the Medicare umbrella because our taxpayers are writing a check to a private company. That is why it gets included as part of Medicare. Other than that, it is a private plan.

Mr. BAUCUS. This is a semantic question. When you see the operational effects, as my good friend from Connecticut said——

Mr. WICKER. One other question. Is it a semantic question to ask: Are the American seniors who are currently enjoying Medicare Advantage going to be disallowed from this program? The answer is yes, under this bill.

Mr. BAUCUS. This legislation, if I may say, expressly states there will be no reduction in what is called guaranteed benefits under Medicare. No reduction, whether it is under Medicare Advantage, whether it is under fee for service—whatever it is, no reduction whatsoever.

To be fair to my good friend, I used the words ''guaranteed benefits.'' Guaranteed benefits are the usual benefits seniors think of when they are under Medicare. They go to a doctor, hospital, so on.

We have given, unfortunately, so many additional dollars to the so-called Medicare Advantage plans—way above what they should have received. MedPAC agrees. Senator COBURN totally agrees they have been paid way too much. They have taken advantage of that advantage by giving additional benefits, in addition to the guaranteed benefits. Those additionals are things such as gym memberships—a lot of extra stuff that, frankly, is not part of Medicare, is not directly related to health.

I might say, too—I have said this a couple, three times and I will say it again—a reduction in the increase of payments to Medicare Advantage, the effect of those reductions is a decision made by the officers of that company. They could take those reductions and apply them anywhere. They could reduce their salaries. They could reduce their admin costs. They could take other actions that would reduce the rate of growth, the rate of return of their stockholders. They do not have to take it out of the beneficiaries. That is their choice. They do not have to.

Mr. DODD. Medicare Advantage decides how to use their extra payments to provide benefits. They decide; Congress does not. There is nothing in the legislation that forces plans to reduce benefits at all, rather than reducing profits.

Medicare Advantage is one of the profitable business lines of the private insurance. In fact, the New York Times on November 2—just about a month ago—reported:

Humana, the health insurer, posted on Monday a 65 percent jump in third-quarter profits—

We are talking about private health care. These are profits, a 65-percent jump in profits off this plan—

as bulging membership and premiums from Medicare Advantage overcame a lackluster commercial segment.

I appreciate the fact that people are getting eyeglasses and things. That is wonderful. But we need to be clear about this. These are not the guaranteed benefits, and 80 percent of Medicare beneficiaries get none of these advantages and yet pay more so other people under this private health care plan—because it is subsidized by the American taxpayers—get them.

Again, now we are going to put competitive bidding in place. Our bill allows, under these plans, if they follow and do some of the incentives, to actually share in some of the profits. We are not talking about eliminating all of this plan. We are trying to make it work better for people under the bill.

We have to be honest what we are talking about. This is a private insurance company that is subsidized by the American taxpayers. It is not what, traditionally, people think of Medicare.

Mr. WICKER. Will the Senator yield?

Mr. DODD. I will be happy to yield.

Mr. WICKER. The chairman, when he is calling HHS to change the handbook, also needs to tell them to change their Web site, where it says Medicare Advantage is part of Medicare.

Can the Senator from Connecticut guarantee that under this legislation, the benefits to Medicare Advantage recipients will not be cut? Can he make this guarantee?

Mr. DODD. What I wish to say and what I wish to ask my colleague—

Mr. WICKER. The reason he cannot make this guarantee—

Mr. DODD. Let me claim my time. There is not a single guaranteed benefit under Medicare that is cut in this bill. Not one. I defy any Member of this body to identify a guaranteed benefit under Medicare that gets cut. You cannot find one. Do we cut out gym memberships and things such as that? Yes, that may happen. But on the guaranteed benefits—operative word is ''guaranteed''—under guaranteed benefits, there is not a single cut to a benefit. That is why an organization representing 40 million Americans that endorsed the Bush prescription drug plan, by the way, in 2003—hardly a partisan organization as some have suggested today—has basically opposed

the McCain motion and has endorsed the legislation before us today. That organization, I say to my good friend, would never be endorsing a bill that was going to cut guaranteed benefits under Medicare.

Mr. BAUCUS. I wish to say something else to put this in perspective. That is according to analysis of Medicare Advantage plans from Oppenheimer Capital Fund, dated November 12 of this year, between 2006 and 2009. Their estimate is, Medicare Advantage accounted for nearly 75 percent of the increase in gross profits among the larger Medicare plans in the industry.

Let me say this:

. . . Medicare Advantage . . . has been a huge driver—

Quoting from the Oppenheimer Capital Fund—

a huge driver of earnings growth for the industry in recent years. Between 2006 and 2009, we estimate that Medicare Advantage accounted for nearly 75 percent of the increase in gross profits among the larger plans in the industry, highlighted by an estimated gross profit increase of $1.9 billion in 2009, relative to commercial risk earnings gains—

That is basic health insurance, not Medicare Advantage plans but basic health insurance—

of nearly $600 million. Medicare Advantage probably won't be as much of a contributor in 2009—

But it is going to be a very large contributor in 2009 because of advantages they get.

Mr. WICKER. It is clear the Senator does not like Medicare Advantage. It is also clear no guarantee can be made that Medicare Advantage benefits will not be cut under this legislation. It is also clear there are tens and tens of millions of American senior citizens who like their Medicare Advantage, notwithstanding the Senator from Montana, and they stand to lose those benefits under this legislation.

Mr. DODD. Let me point out, one of the things we have not talked about, I say to my friend from Mississippi, under our legislation, this bill protects seniors in Medicare Advantage from plans that care more about profits than seniors, trying to pass the buck. Under our bill, it allows the Secretary of Health and Human Services to kick out any plan under Medicare Advantage that significantly increases their premiums or decreases their benefits. Under existing law, that would not happen; under our bill, it does.

It is not about being hostile to Medicare Advantage. It is being realistic about all this and trying to make the tough decisions we have to make about trying to stabilize Medicare, seeing to it we are going to have protections in premium reductions and cost savings, as well as increasing access and quality.

All we are trying to point out is, when you have a Medicare Advantage plan that has run as poorly as this one has, at great cost we now learned—14 percent above, on average; some places it is 50 percent above average—where is the equity. By the way, I say to my friend from Mississippi, it is a private health care plan that receives subsidies from the American taxpayers, where 80 percent of seniors today pay more and get nothing for it. Where is the equity in this? There is no equity in this. Why should 80 percent of that population pay $90 or more a year, on average, for a benefit they don't get? Where is the equity?

Mr. BAUCUS. I might add, too, to remind us all, this legislation provides additional benefits for all seniors, including Medicare Advantage recipients—additional benefits. What are they? No copayment for certain preventive care—mammograms, for example, colonoscopies, screening benefits that are not in existence today. There are a whole host of other things that are additional.

This legislation provides additional benefits to Medicare Advantage members that are not there today.

When I say ''guaranteed benefits,'' I am talking about the usual benefits seniors think of under Medicare. It is hospital care, it is nurses, it is all medically necessary physician care, diagnostic testing, supplies. It is home health care, preventive care, skilled nursing, hospice—all the things that are basically related to health care.

The only thing that might be trimmed back a little is, I call them the fringe stuff, the excesses, such as gym memberships. I wish I had the whole list because some of them are not related.

As I said earlier, they may not be cut. They don't have to be. It is up to the private companies whether to cut. I have nothing against companies making profits. They should make profits. It is our responsibility as Senators to make sure the reimbursement rates Medicare pays providers are fair and reasonable and not excessive. We have been told they are excessive. So we are trying to find a way to make it fairer.

Mr. WICKER. This segment of debate will end at the bottom of the hour, so it is almost over. I appreciate my friends yielding. This debate will continue for days, weeks. I say to my friends, there are Members on their side of the aisle who have come before this body and said these Medicare Advantage cuts are unacceptable. I think they are going to have to have a lot of convincing too. Democratic Members of the House have also come forward. I am not convinced. I don't think they are convinced.

The PRESIDING OFFICER. All time has expired.

Mr. DODD. Madam President, I ask unanimous consent for 2 additional minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DODD. Madam President, let me say to my colleague again that here we have two organizations representing 43 million seniors in our country, and these are organizations that don't just write letters on the fly. They have staffs that examine proposals here, and that is all they do. We have AARP, which is an organization that is highly regarded and well recognized, representing 40 million seniors in the country, and the Commission to Preserve Social Security and Medicare, which represents an additional 3 million, and that is all they do. This is a totally nonpartisan examination. These two organizations, representing almost 50 million of our seniors, have examined this bill in detail—every dotted ''I,'' every semicolon, every comma, every proposal—and have done exhaustive research, and they have said: This is a good bill. This bill is deserving of support.

We received a letter today from them. They are not Democrats. They are not Republicans. They are not trying to get an advantage over anybody. They are examining whether this bill stabilizes and strengthens Medicare, puts seniors in a stronger position, is going to see to it that we can extend the life of the program and provide guaranteed benefits that are needed, and their answer was a resounding yes—yes, this bill is deserving of our support.

Again, I appreciate the political debate here, but at some point we have to step back and let those whose job it is to analyze our suggestions and our ideas—just as AARP supported President Bush 6 years ago with his prescription drug bill. They didn't join Democrats or Republicans; they liked the idea—still do—and supported it. Today, they are not supporting us as Democrats. They would reject this bill out of hand if they thought we did something adverse to the interest of their membership. But they said: No, this is a good bill, deserving of support. The two largest organizations in this country representing seniors have said: Get behind this bill. Let's support our seniors. Let's make Medicare stronger and strengthen it. And this bill does it.

That is why we should be joining together, not fighting over this. Medicare Advantage is a private health care plan subsidized by the American taxpayer. Eighty percent of the seniors don't get the Advantage. That is why we are creating these changes in this bill.

I applaud my colleague from Montana, the chairman of the Finance Committee, who did incredible work, along with his staff and other members, in producing this product.

RECESS

The PRESIDING OFFICER. The Senate stands in recess until 5:30 p.m.

Thereupon, the Senate, at 4:33 p.m., recessed until 5:30 p.m. and reassembled when called to order by the Presiding Officer (Mr. WHITEHOUSE).

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009—(Continued)

(Mrs. SHAHEEN assumed the Chair.)

Mr. WHITEHOUSE. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. WHITEHOUSE. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WHITEHOUSE. Madam President, I intend shortly to call up an amendment once the procedural posture is clarified and has been cleared on the Republican side, an amendment to protect the Social Security surplus and the CLASS program savings in this act. When I do, I will then ask for its immediate consideration, but at the moment, that is still being worked out from a parliamentary standpoint, so my words will come in advance of that.

I wish to describe the amendment for my colleagues. It is a sense-of-the-Senate resolution that demonstrates the Senate's commitment to meaningful deficit reduction in this legislation while also protecting both the Social Security surpluses generated by the legislation and savings generated from a significant element of the bill, the long-term voluntary insurance program created by the Community Living Assistance Services and Supports Act, what we call the CLASS Act. The amendment expresses the sense of the Senate that surpluses generated by this bill for the Social Security trust fund be reserved for Social Security and that the savings for the long-term insurance program created by the CLASS Act be reserved for the CLASS program.

The CBO has estimated that this bill will save $130 billion over the first 10 years and roughly $650 billion over the next 10 years. This amendment stands for the proposition that these impressive savings will be protected vis-a-vis the CLASS Act and the Social Security trust fund.

I wish to speak in particular today about the CLASS Act. This act creates a voluntary insurance program for seniors and individuals with disabilities. This program will enable them to afford long-term care even after they have exhausted coverage offered by Medicare or their private insurer. Let me make clear that this is not a mandatory program. It does not increase taxes on anyone. It is a completely voluntary program that offers an additional insurance option for the disabled. Without such insurance, disabled people often cannot afford the massive costs of long-term care. Under current law, they are often forced to sell their homes or otherwise what is called ''spend down'' their assets until they meet a poverty threshold before they can begin receiving the help they need.

Certain colleagues on the other side of the aisle have argued that the CLASS plan would lead to a financially unstable entitlement program and would rapidly increase the Federal deficit. That is simply not accurate. The CLASS plan is fully self-sustaining and actuarially sound, funded by the premiums paid by those individuals who voluntarily opt into this insurance plan. There are no taxpayer dollars involved.

After individuals pay premiums for 5 years, they become eligible to receive a cash benefit of no less than $50 per day to assist with the various costs associated with the onset of a disability or long-term health condition. These benefits could be used to pay for transportation to work, for instance, or the construction of a wheelchair ramp or the hiring of a personal aide—the sorts of things that so often make the difference between somebody remaining an independent and productive member of society and requiring the support of assisted living or nursing home care.

I think we can all agree that it is in everyone's best interest to try to provide this kind of assistance to people when an unexpected disability begins to affect their lives, to allow them the support they need to continue as best they can in their homes, in their apartments, with their families, at their jobs, and remain, as I said, both independent and productive.

The Congressional Budget Office has concluded that this plan is fiscally solvent. In fact, it projected that the program would be solvent for at least 75 years.

There was a helpful amendment offered in the HELP Committee when we considered and debated and passed that piece of legislation. The amendment was offered by the distinguished Senator from New Hampshire, your colleague, Senator GREGG, the ranking member on the Budget Committee. It passed unanimously, and it ensures and requires that the program be actuarially sound for 75 years.

CBO has projected that, in fact, it would be solvent for at least 75 years. CBO further estimated that the program would reduce the deficit by $72 billion over 10 years, saving $1.6 billion for Medicaid during the first 4 years of the program. So it has a substantial fiscal upside.

I am surprised that our colleagues on the other side are criticizing this element of the bill. It seems to run contrary to the findings that have been made by the nonpartisan Congressional Budget Office. It is certainly a stark contrast to their tolerance for their own Medicare Part D Program, the pharmaceutical program the other side touted so proudly, which is different from the CLASS Act in many respects: It was vastly expensive; it was completely unpaid for; it was a massive handout to the pharmaceutical industry, containing within it the, to me, appalling proposition that the government was forbidden by law, forbidden by a previous Congress, to negotiate with the pharmaceutical industry over the price of drugs and had to take it or leave it, whatever the pharmaceutical industry charged. Frankly, it is irresponsible to put the government into that situation. It is fiscally irresponsible, and it is irresponsible from a management point of view. It is irresponsible in more ways than I can name. Yet they happily went that way, the path of fiscal irresponsibility, when it suited the pharmaceutical industry. Of course, in order to do so, they had to leave a hole in the Part D pharmaceutical program for seniors to fall into, what the Presiding Officer knows well and what my colleagues know well as the dreaded doughnut hole that has caused so many unsuspecting seniors so much surprise, chagrin, fear, anxiety, and misery. Now, having been the architects of that program, they criticize the CLASS Act even though the CBO has found it to be fiscally sound.

It seems there is an enormous double standard between programs designed for the benefit of, say, the pharmaceutical industry, or perhaps the insurance industry, and the standards they would apply to programs that benefit people who suffer from the onset of a disability—regular Americans, regular families. This is something that happens to people across this country all the time.

That is really the most important effect of the CLASS Act. As good as it is on deficits, as much as the CBO has confirmed that it is to our fiscal advantage to proceed with the CLASS Act, the most important effect is not on deficits, it is on people.

It is on families. This insurance program will allow disabled people, young and old, to live more financially secure and productive lives, free from the fear that medical expenses will impoverish or bankrupt them, able to make those investments in their own adaptation to their disability so they can maintain the lifestyle, the job, and the home they are accustomed to and comfortable with. Studies show that less than a quarter of private long-term care insurance policies provide a lifetime of benefits. The CLASS Act fills an important void that has been left by the public sector for people who seek this protection and this insurance on a paid-for basis. The CLASS plan is a win-win for reducing costs in our health care system and protecting Americans who require long-term care. Our current system plain fails to protect those who aren't healthy or wealthy enough for private market coverage. It fails to create an opportunity for individuals to plan and save for their future lifetime care needs. It fails to provide a sustainable safety net for individuals who require long-term services and supports to keep the familiar aspects of their life around them—job, family, home, hearth.

I will shortly ask that my colleagues support the amendment when it is called up. It will put the Senate on record as protecting Social Security. It will put the Senate on record as protecting the CLASS Act savings scored by CBO. It will put the Senate on record as supporting the impressive deficit reduction in the bill. I look forward to favorable consideration when we have a parliamentary agreement on calling it up.

I yield the floor.

The PRESIDING OFFICER (Mr. UDALL of Colorado). The Senator from New Hampshire.

Mr. GREGG. I appreciate the proposal of the Senator from Rhode Island, but I think it needs to be put in its proper context. This is a sense of the Senate. It has no legal implications. The CLASS Act, as proposed in the underlying bill, was described by the Senator from Rhode Island but not fully. The way the CLASS Act works, it is an insurance program theoretically where people in their thirties and forties and fifties can buy insurance to cover their retirement years when they have to go into some sort of long-term care facility and may be institutionalized. People are paying into this program for decades, maybe four decades, maybe their thirties right into their seventies or their twenties into their sixties. The cost of this program does not actually start to be incurred until these folks move into a long-term care facility or a managed care facility type of situation for their retirement years where they need skilled nursing assistance of some sort.

There is a huge amount of premium that comes in under this program early which goes against virtually no expenses, because this is a brandnew program. It is a startup program. It is created by the Federal Government. It is a government insurance program much like Social Security and Medicare. The practical effect of that is that money will come in for years to the Federal coffers. In the first 10 years of this bill, it is estimated around $90 billion will come in. In the second, as we move out in the second 10 years, the total over those two periods of 10 years is about $212 billion. Then more money will come in in the third 10 years, probably somewhere in the vicinity of $300 billion to $400 billion potentially. None of this will be spent on the purposes of this insurance, because almost everybody who is paying in for these premiums is going to be too young to go into one of these institutionalized care facilities during those first three decades.

So what happens is that the Federal Government gets this large windfall of money from these people who are paying their premiums and spends it, spends it on something else—education, roads, highways, arts, whatever is the decision on where to spend the money. It gets spent. That is the way the Federal Government works. It doesn't have any place to put this money and keep it safe. It comes in, and it gets spent. When these people retire, when they do go into a situation where they need assisted living of some sort, then the government gets the bill. Not us, not those of us who are here. We will be long retired by then, everybody in this Chamber, except maybe Senator BENNET from Colorado who is rather young and vibrant. The rest of us will probably not be around to take advantage of this. It will be our children and grandchildren who will end up with that bill.

That bill will be staggering. We are talking hundreds of billions, if not trillions, of dollars of outyear costs as a result of this type of program; much like Social Security which basically has nothing in the coffers today, even though trillions of dollars have been paid in, but which has a lot of obligations. The same thing with Medicare. That was an insurance program which was supposed to have money in the coffers. Not there. In fact, it goes into negative cashflow and will be insolvent beginning in 2010. There is no money when these folks retire and need it. It will have been spent.

This amendment, well intentioned as a statement, has absolutely no effect on that series of events. That money will still be spent under this amendment. After this amendment is passed—and I presume it will be passed; it is a nonevent amendment having no purpose other than a political statement—CBO will still score this bill as spending that money, absolutely score this bill as spending that money, the $90 billion for the next 10 years, the $212 billion for the next 20 years, the $400 billion after that. That is my guess. The third 10-year period, my guess is $500 billion. When we get out there 30, 40 years from now and these people expect to get their insurance paid, then when our children get the bill for that insurance, it becomes a tax on them, a direct tax on their earnings. It will affect their lifestyle, their earning capacity, their ability to buy a home, to send a child to college, to buy a car. This money will be spent under this bill.

One of my colleagues on the other side of the aisle who is pretty respected around here on financial matters I believe referred to this CLASS Act proposal as a Ponzi scheme. That is not too far off. Basically, we are taking the money from these folks who buy into this insurance program today. We are spending it on something we want to spend it on as a Congress today, whether it is something worthwhile such as a road or education or our national defense, but we are spending it. We are leaving the people who paid that premium out to lunch unless 30 or 40 years from now, when they go into that situation where they need that insurance, the country is strong enough and our kids are making enough money to pay for the cost of that program. That is a real gamble for them, and that is called a Ponzi scheme, which is exactly what this is. This bill, this sense of the Senate, although a good political document because it allows Members to wander around their districts and say: I voted to protect the CLASS Act dollars, I voted that it not be accounted for under this bill, that was a sense of the Senate. In actuality, it has no effect at all in that area.

All the money that comes into this, insurance money, is going to be spent somewhere else. And the CBO will still score this bill as taking credit for that insurance under this program. It is Bernie Madoff accounting one more time under this bill. You would think after a while people would get embarrassed—really, it would become embarrassing after a while. When you match up 10 years of tax increases, 10 years of Medicare cuts, to 5 years of programmatic spending and claim you have a program that is fully paid for and is only an $840 billion program, when you know that if the program, the entire bill is fully phased in, it is $2.5 trillion in cost. It isn't $500 billion in Medicare cuts when this thing is fully phased in, it is $1 trillion in Medicare cuts. It isn't $500 billion of tax increases in this bill and fee increases on small businesses mostly or on provider groups, it is over $1 trillion of increases. You would think after a while people would be embarrassed about the manipulation of numbers in that way. But that doesn't seem to occur. Yet we get this proposal that says, OK, let's do it again. Let's claim we are doing something we are not doing. Let's claim we are protecting the dollars that come in under this new CLASS Act proposal, assuming this program goes into place. Let's claim we are segregating them somehow so the people who pay their hard-earned dollars and buy into this CLASS Act think they are getting something for it, when in fact that will not happen at all, is not going to happen at all. That money is going to be spent the day it comes in. In fact, it is already spent. We are already borrowing so much and spending so much in this government right now. We already have an obligation of debt that will spend this money.

I guess everybody can walk away feeling good about this amendment, but substantively, it has no impact at all.

Mr. THUNE. Will the Senator yield for a question?

Mr. GREGG. I am happy to yield.

Mr. THUNE. My understanding is as to the CLASS Act, to make the deficit situation with the enactment of this bill look better, they argue they are actually going to reduce the deficit as a result of this bill because of the revenues that come in early from the CLASS Act. I think the Senator from New Hampshire has accurately described this. You get a short-term infusion of revenues and another long-term liability which is why the Senator from North Dakota described it as a Ponzi scheme of the highest order, something of which Bernie Madoff would be proud. I guess my question to the Senator would be, how does this impact deficits in the long run and the debt in the long run? There was a lot of discussion around here, probably more rhetoric than action, about doing something to reduce the deficit and deal with the debt that continues to pile up and accumulate and at some point will be handed off to future generations. This Ponzi scheme, as it has been described by the Senator from North Dakota on

the other side, in the form of the CLASS Act does seem in the short term to understate the fiscal impact of the cost of this health bill which, as the Senator from New Hampshire has described, is $2.5 trillion. But could the Senator elaborate on what happens in the outyears? You talked about the impact down the road when all the bills come due. You get all the revenue in the short term, and then some time down the road that revenue gets spent and you are stuck with all these liabilities. How is this going to affect deficits and debt in those years in the future when our children and grandchildren will have to pay for it?

Mr. GREGG. The Senator has asked a very pointed and appropriate question, because the answer is pretty startling. The point I think most people don't understand is that this money gets spent as it comes in. In other words, let's say over the next 30 years, younger people pay into this new alleged insurance program, accurately described as a Ponzi scheme. All that money that comes in will be spent on other activities of the government and, therefore, the other activities of government will be allowed to grow fairly dramatically. There will be a lot of money here. You are talking potentially $1 trillion over the next 30 years.

Those expenditures, which will have occurred as a result of this money coming in, which will have nothing at all to do with paying for the cost of the health care which these people who buy into this CLASS Act think they are getting—in other words, long-term care insurance, it has nothing to do with that—it will be on, as I said, education, roads, national defense, whatever we spend it on around here. Those expenditures will be built into the baseline forever. They will presume that there is going to be revenue to pay for them. What happens when that generation that has bought into the CLASS Act starts to actually need the money it is alleged it is going to get? Two things happen. The younger generation is going to have to pay taxes to cover that cost because the money will not be there. There will be no money in the kitty, none, zero. There will be zero money in the kitty, the alleged kitty to pay for this insurance program. Second, ironically, the government will have been grown by all the money that came in and was spent on new programs. So you are basically going to double down on the cost here.

Our children and our grandchildren are going to have to pay twice, not only to pay for the long-term care which allegedly has been promised to these people under these insurance programs but also to pay for all the new spending that will occur as a result of spending the premiums which were supposed to be saved for these programs. So they are going to get hit twice. The implications are, quite honestly, staggering.

We already know we have a $38 trillion unfunded liability in Medicare. We know, when you combine Medicare, Medicaid, and Social Security, we have a $60 trillion unfunded liability. If you calculate in the cost of the CLASS Act on top of that, you are adding potentially trillions more of unfunded liability, which will all have to be paid by our children and our grandchildren.

At the essence of this bill, there are a number of problems, but the problem I find most inappropriate in the way we are doing this is we are creating a government which our kids cannot afford under any circumstance. We are absolutely guaranteeing that our children are going to have a lower standard of living than we had because of the burden we are going to put on them as a result of these expansive new programs, which we know cannot be afforded in the outyears.

We already know we cannot afford the government we have in the outyears. We already know the public debt is headed above 80 percent of GDP by 2019. So the Senator from South Dakota has touched on a core issue. What is the real cost of this? Well, it is extraordinary. As I said, it hits the next generation twice. First, they will have to pay the taxes to pay for the program that was put on the books, which is allegedly there, plus they will have to pay to support all the programs which the money that came in was supposed to be preserved for.

Mr. THUNE. I say to my colleague from New Hampshire, it is the classic definition of a Ponzi scheme, which, as I said, is how it has been described not just by the chairman of the Budget Committee from North Dakota but also by others who have looked at this. Editorial pages in newspapers across this country have looked at this CLASS Act and said it does not add up, and it does not add up. I think Ponzi scheme is a good description.

The Senator from New Hampshire has correctly outlined the impact this will have on future generations, on deficits and debt, and spending and the growth of government. That is why it is such a bad idea to include this. The sense of the Senate resolution is simply that. It has no legal binding effect on spending. It simply is sort of a political statement that makes everybody feel better, but in the end it is going to be our kids who pay.

Mr. GREGG. I think the Senator from South Dakota touched on another point. The sense of the Senate, basically, confirms the fundamental flaw of the CLASS Act. The fact that you would think a sense of the Senate is necessary pretty much proves that everybody around here understands there is a big game going on with the CLASS Act. The problem is, of course, the sense of the Senate has no effect of law and, therefore, the problems the CLASS Act creates in the area of spending, the revenues that come in for the purpose of something other than what the CLASS Act alleges people are buying when they pay for that insurance, will still exist, and the CBO will still score the CLASS Act as benefiting the budget situation, when it should not be scored that way at all.

As I said, this is a nice resolution from a political standpoint, but substantively it has no effect on correcting the problems which the CLASS Act generate in the area of fiscal policy.

I understand there is a unanimous consent request that somebody wishes to offer. I was asked if I would listen to it.

Mr. DURBIN. Mr. President, does the Senator yield the floor?

Mr. GREGG. I ask the assistant leader, is he offering a unanimous consent request? I will yield the floor for the purposes of a unanimous consent request.

Mr. DURBIN. Mr. President, I ask unanimous consent that the next amendment in order be one offered by Senator WHITEHOUSE of Rhode Island, which is at the desk; that the other matter in order during today's session be a Hatch motion to commit regarding Medicare Advantage; that no other amendments or motions to commit be in order during today's session; and that the time in sequence following this unanimous consent request—I do not want to disadvantage the Senator from New Hampshire, but if it is our turn on this side of the aisle, I would ask that Senator WHITEHOUSE first be recognized for the purpose of calling up his amendment and then I be recognized next, for no more than 15 minutes; and at that point it is my understanding Senator HATCH has asked for the floor for 1 hour on his motion.

If there are any other requests, I would be glad to add them to the unanimous consent request at this point.

Mr. GREGG. Reserving the right to object, my only concern would be that will take us past 7 o'clock, so you may want to adjust the time.

Mr. DURBIN. I am going to finish this as soon as I have gone through my preliminary work here. I also ask unanimous consent that the time until 8 p.m., this evening, be equally divided and controlled between Senators WHITEHOUSE and HATCH or their designees; that it be in order during this time for Members to engage in colloquies, as long as those Members entering into the colloquy remain on the floor.

Mr. GREGG. Is it my understanding, then, the order of recognition will be Senator WHITEHOUSE, the assistant leader, and then Senator HATCH?

Mr. DURBIN. Yes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Rhode Island.

AMENDMENT NO. 2870 TO AMENDMENT NO. 2786

Mr. WHITEHOUSE. Mr. President, I now call up amendment No. 2870, an amendment to protect the Social Security surplus and CLASS program savings in this act and ask for the amendment's immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Rhode Island [Mr. WHITEHOUSE] proposes an amendment numbered 2870 to amendment No. 2786.

Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To promote fiscal responsibility by protecting the Social Security surplus and CLASS program savings in this Act)

At the appropriate place, insert the following:

SEC. ___. SENSE OF THE SENATE PROMOTING FISCAL RESPONSIBILITY.

(a) FINDINGS.—The Senate makes the following findings:

(1) Based on Congressional Budget Office (CBO) estimates, this Act will reduce the Federal deficit between 2010 and 2019.

(2) CBO projects this Act will continue to reduce budget deficits after 2019.

(3) Based on CBO estimates, this Act will extend the solvency of the Medicare HI Trust Fund.

(4) This Act will increase the surplus in the Social Security Trust Fund, which should be reserved to strengthen the finances of Social Security.

(5) The initial net savings generated by the Community Living Assistance Services and Supports (CLASS) program are necessary to ensure the long-term solvency of that program.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the additional surplus in the Social Security Trust Fund generated by this Act should be reserved for Social Security and not spent in this Act for other purposes; and

(2) the net savings generated by the CLASS program should be reserved for the CLASS program and not spent in this Act for other purposes.

Mr. WHITEHOUSE. Mr. President, I yield the floor to the distinguished assistant majority leader.

Mr. DURBIN. Mr. President, I have listened carefully to the profound and eloquent statements from my friend and colleague from New Hampshire, Senator JUDD GREGG. He has frequently invoked the name of the Ponzi family, though I am not personally familiar with them. I believe they have had some skeletons in their closet by virtue of the references that have been made. But I will tell him that what he said about the CLASS Act is inaccurate.

I know that Senator, I see, is leaving the floor. I hope he does not miss out on this conversation. But—

Mr. GREGG. I was just wondering if the Senator would yield for a question.

Mr. DURBIN. I would be happy to.

Mr. GREGG. Is the Ponzi family from Chicago?

Mr. DURBIN. No, they are not. I think they are from New England—Patriots' fans.

I would like to ask the Senator from New Hampshire, if he would yield, if he is familiar with Doug Elmendorf and the Congressional Budget Office and the letter of November 18, 2009, to the majority leader, HARRY REID, in relation to the deficit impact of the CLASS Act.

Mr. GREGG. I appreciate the assistant leader asking me that question. Regrettably, I am not immediately familiar with it. I have probably seen it, although I apologize for not being immediately familiar with it. Therefore, I presume the assistant leader is going to remind me or at least reacquaint me with its terms. I would note the term ''Ponzi Act'' did not come from me. It came from the chairman of the Budget Committee.

Mr. DURBIN. I would just say, it is unfortunate the Senator from New Hampshire has not seen this letter because if he had had an opportunity—and it is impossible to read everything—if he had had an opportunity to read that letter, I do not think he would have made the speeches he just made on the floor about the CLASS Act because the Congressional Budget Office tells us that in the first 10 years, the CLASS Act will reduce the Federal budget deficit by $72.5 billion; in the second 10 years by a substantial amount, though somewhat less than $72.5 billion; and in the third 10 years—30 years out—it is anticipated it will add to the deficit, but, in the words of the letter from the Congressional Budget Office, by a very small amount over that next decade.

Mr. GREGG. If the Senator would allow me to comment on that one point?

Mr. DURBIN. I would be more than happy to allow that.

Mr. GREGG. I fully agree with that analysis. The first 30 years of the CLASS Act will generate revenues. It will add to the Federal Treasury and will—and that was the purpose of my discussion; that is the point I made—during the first 30 years of this proposal, younger people will be paying in and very few people will be taking out because they will not have yet qualified for the insurance because they will not be old enough to go into assisted living.

Mr. DURBIN. Reclaiming the floor, I would just say, if I understand what the Senator said, he is concerned that in the year 2040, this program may not work as effectively as we had hoped it would work. I trust in the wisdom of future Members of the Senate and the House, if that is necessary, to modify the program.

But it certainly is worthwhile for us to at least reflect on what this program is. It is a voluntary, self-funded insurance fund for long-term care for American citizens. It was one of the visions of Senator Kennedy as part of health care reform, understanding we are living longer and many times need help in our late years in life and it can be expensive and deplete a family's savings. Senator Kennedy said: Let's try to put together a voluntary program where you can pay in and have, in fact, long-term care insurance available to you, if you need it.

The fact that this program is virtually solvent for 30 straight years is an indication of the wisdom of that idea and the way it is planned.

I might add one other thing. We just finished a motion to commit on the floor relative to Medicare, and many of us argued that the bill before us, the bill that represents health care reform in this debate, protects Medicare and guarantees the basic benefits of Medicare. Those on the other side of the aisle protested and said: No, it does not.

Well, then, Senator MICHAEL BENNET of Colorado offered an amendment which said, pointblank and clearly, nothing in this bill will, in any way, diminish guaranteed Medicare benefits, and a surplus generated here will be to give a longer life to the existing Medicare Program. The Bennet of Colorado amendment passed 100 to nothing, so not only does the bill originally protect Medicare, the Bennet amendment repeated that, and all the Republicans voted for it. Yet they continue to come to the floor and say: We do not believe what we voted for. We believe this bill is going to hurt Medicare.

The same thing is true with the CLASS Act because Senator WHITEHOUSE, who was on the floor momentarily, came forward and said: I will put it in writing. We are going to put it in writing that the surplus in the CLASS Act program cannot be used for other purposes and has to be saved and used for the purposes stated here for long-term care insurance. I think the Whitehouse amendment is likely to get another 100 votes.

So every time we address a concern from the Republican side of the aisle, and say the bill addresses that concern or a separate amendment addresses that concern, they protest: It is not enough. We need more. I think they protest too much.

I would also say I am troubled today, as I have been for several weeks, by the position taken from the Republican side of the aisle about health care reform. For about 13 or 14 days, this bill, in its entirety, has been available to the American people. You can find it by Googling ''Senate Democrats'' and it will direct you to our Web site and you can click on this bill, H.R. 3590, and read it, page after page—all 2,074 pages of it. That is the way it should be.

There was a lot of angst and worry last August in townhall meetings: Well, are you going to get this bill sneaked by us? Are we going to get a chance to read it? Everybody has a chance to read it. But then I would recommend to those who are searching the Internet to read health care reform bills that if you want to find the Republican health care reform bill, look for ''Senate Republicans'' and go to their Web site and you will be able to click on ''health care reform bill'' and you will find the Democratic health care reform bill because, unfortunately, there is no Republican health care reform bill. They have not offered one. They have had a year to prepare

it. They have had plenty of ideas they have expressed on the floor. They have been critical of our efforts. They have offered literally hundreds of amendments in committee, and yet they cannot come up with a bill.

It leads you to conclude this is not an easy task. It is not easy at all. It certainly is not easy to produce a bill such as this one, the Democratic bill, which generates, over the first 10 years, a $130 billion Federal surplus in our Treasury. This bill adds more in terms of surplus and deficit reduction than any bill in the history of the Senate. In the second 10 years, the Congressional Budget Office says there will be another $650 billion in savings on our deficit.

So for those who argue if we pass this bill we are going deeper in debt, they ignore the Congressional Budget Office, that referee that takes a look at all the bills and tells us that over the span of 20 years, we are going to reduce our deficit by some $700 billion or $800 billion, just by virtue of this bill. Republicans have been unable to produce a bill that reduces the deficit, when it comes to health care, by a penny. They come here and criticize what we have done, but they can't produce a bill. All the great legislative minds on their side of the aisle, and we have been waiting patiently for them to produce a health care reform bill. They can't or they don't want to. Maybe they like the current health care system. Maybe they think this is the way America should be.

Well, many of us don't believe that, and a lot of Americans don't either. There are a lot of good parts of our system we want to protect, but there are many parts that need to be changed. We need to make health care and health insurance more affordable for families and individuals and businesses. This bill does.

We just had another report from the Congressional Budget Office that said yes, the cost of premiums will be coming down for many Americans as a result of this bill. We also understand that some 50 million Americans don't have health insurance at all. This bill will reach the highest level of protection for health insurance in the history of the United States. Ninety-four percent of people in this country will have the peace of mind and security of health insurance—a dramatic increase. The Republicans have been unable to come up with any proposal that moves us toward more coverage for people who don't have health insurance.

This bill also has many provisions to finally give consumers across America a chance to fight back when the insurance companies say no, and they do all the time. People who need critical surgical procedures and medicines, people who need the kind of care their doctors recommend end up fighting with the clerk at an insurance company. This bill, the Democratic health care reform bill, gives these families a fighting chance against these health insurance companies. I have yet to see the first bill coming from the Republican side of the aisle in the course of this debate that would give our families a chance against these health insurance companies.

I wish to also say when I finish speaking, and we finish on this side of the aisle, the Senator from Utah will come and speak. I understand it is the Medicare Advantage Program he will speak to. Now, the previous motion to commit by Senator MCCAIN of Arizona said: Send this bill back and make sure you take out any reference to savings in the Medicare Advantage Program. That was defeated. The vote was 42 to 58. There were two Democrats who joined the Republicans. They needed 60 votes; it didn't make it. I take it the Senator from Utah may offer another motion to commit relative to Medicare Advantage. I expect it to have the same fate, but he has his chance to argue his point of view, and he may be persuasive to more Members on this side of the aisle. Unfortunately, although we are good, close friends, and I bask in his wisdom on a daily basis, he is not going to change my mind on this issue because the Medicare Advantage Program is a program that needs to be changed.

Let me tell my colleagues about this program. We started years ago with the health insurance industry telling us: Government cannot do a good job when it comes to insurance. Let us show you how private health insurance companies can sell a Medicare policy more cheaply than the government. And we invited them to do it.

Over the course of the years, some of them did. They showed some savings, and they demonstrated to us they could provide Medicare at a cost lower than the government. But then things changed, and the health insurance companies kept coming back and saying: Well, we actually need more money now to provide the same benefits in Medicare that the government provides.

At last count, the Medicare Advantage Program costs 14 percent more to provide the same Medicare benefits as the government program. So these leaders in the private sector who were going to teach us a lesson about how to sell insurance ended up failing their own lesson plan, and now this Medicare Advantage Program has turned out to be a flatout subsidy to the health insurance industry—$170 billion over 10 years. In other words, the Medicare Program is paying more for Medicare than what it has to pay so it can subsidize health insurance companies which are turning multimillion-dollar profits and giving bonuses to their CEOs.

Some on the other side of the aisle think we need to preserve this; that we need to preserve this subsidy, make sure we protect the profits of the health insurance companies, and we need to protect Medicare Advantage. Well, as Senator DODD has said so frequently on the Senate floor, Medicare Advantage is neither Medicare nor an advantage.

I believe, and most agree, it is time for this party to end. These private health insurance companies didn't keep their word, didn't keep their promise, and because of that we are in a situation—a predicament—where we are asking other people covered by Medicare to subsidize the profits of these private health insurance companies. What does it cost every Medicare recipient in America to provide this subsidy and profits to these private health insurance companies under Medicare Advantage? Ninety dollars a year, on average.

So those who are defending the Medicare Advantage Program as we currently know it and don't support the reforms in this bill are also supporting a $90 annual tax on Medicare recipients. My fiscally conservative Republican friends who run against taxes every chance they have should reflect on the fact that they are protecting a tax on Medicare recipients. That, to me, is indefensible.

Mr. WHITEHOUSE. Will the assistant majority leader yield?

Mr. DURBIN. I am happy to yield to the Senator from Rhode Island.

Mr. WHITEHOUSE. I just wanted to ask the distinguished assistant majority leader to yield for a question through the Chair. Since the distinguished assistant majority leader was here at the time, and I am newer to this body and was not here at the time when the Medicare Advantage Program was originally proposed, I wonder if the distinguished assistant majority leader would remind us of what the promises and assertions were that were made by the private insurance industry at that time as they sought this foothold to get their hands on this Medicare population.

Mr. DURBIN. It was very basic, I would say to the Senator from Rhode Island through the Chair. They just said: Now, listen. When it comes to insurance, the government never gets it right. The bureaucrats who work for the government, those Federal employees, don't get it right. We do this for a living. We can show you how to provide Medicare benefits and save money. So, please, would you just step aside? The private health insurance companies are going to demonstrate to you how much money we can save.

Initially, there were some savings; I will say that in fairness. But over the years, they got greedy, and their greediness led in most recent times to—I think in 2003, if I am not mistaken, with the Medicare prescription drug program, when they came in and these same private health insurance companies said: Now we really need subsidies to keep offering our wonderful programs, now they tell us they are charging 14 percent more than basic Medicare.

The PRESIDING OFFICER. The Senator from Illinois has used 15 minutes.

Mr. DURBIN. Mr. President, I ask unanimous consent for 5 additional minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BROWN. Mr. President, will the Senator yield?

Mr. DURBIN. I am happy to yield.

Mr. BROWN. I thank Senator DURBIN for his recollection and Senator WHITEHOUSE for his question and the comments and understanding of this. My recollection was back 10 years ago when it passed it was the insurance companies that said: We will do it 5 percent cheaper. We will save taxpayers 5 percent. But as soon as they did that, as soon as President Bush was elected in 2000, I remember they started lobbying Congress for more insurance subsidies. It sort of peaked in 2003 with the prescription drug deal giveaway where the drug companies and the insurance companies both got huge government subsidies. They formed the doughnut hole, and seniors ended up paying a lot more so the drug and insurance companies could get subsidies. Then that is when the tax was increased, that $90 tax, if I recall.

Am I right about that, that originally it was actually a good thing for taxpayers, but then during the Bush years the insurance company lobby was able to increase that tax on the other 80 or 85 percent of Medicare beneficiaries, the people who were in what was called fee for service, who would go to the doctor, go to the hospital and submit to Medicare and not do it through a private insurance company? Is that what has happened?

Mr. DURBIN. I would say to the Senator from Ohio that is exactly what happened because what we have is that in order to pay for the subsidy, the private health insurance companies that are selling Medicare Advantage, they had to take the money out of the Medicare system, which meant less money for everybody else. It translated into $90 a year more for every Medicare recipient to pay for the subsidy, for the private health insurance companies that are protected by Medicare Advantage.

Mr. BROWN. If the Senator from Illinois would yield, so these subsidies then went directly to the insurance companies and then the insurance companies—they had to live under the Medicare laws, of course—but these insurance companies then began to insure generally some healthier people so they could make more money, right?

Mr. DURBIN. That is right.

Mr. BROWN. In those days, the insurance companies—Senator WHITEHOUSE has talked often about this, as has Senator HARKIN who is standing here now too—that the insurance companies' business model has been to hire a lot of bureaucrats. They say they are more efficient than Medicare, but surely they are not. Their administrative costs are 15 percent and Medicare is 5 percent. But they hire all of these bureaucrats to keep people from buying policies if they are sick—a preexisting condition—and then they hire a second group of bureaucrats on the other end to make sure those people who submit bills for their health care, their claims, that 30 percent of them are initially denied. So they hire bureaucrats on both ends to restrict care, add a lot of administrative costs.

Medicare, I don't think, prohibits people for a preexisting condition, right? They don't do anything like that.

Mr. DURBIN. No. I would say to the Senator from Ohio the difference is obvious. With Medicare, anyone who shows up age 65 is eligible for coverage, no questions asked, other than your age and whether you have contributed over the course of your lifetime. These health insurance companies cherry-pick the healthiest people they can, then try to deny coverage where they can as well, and that is how they make their profits.

Mr. BROWN. They are pretty good at it.

Mr. DURBIN. So good at it that they are one of the most profitable sectors in the American economy, and virtually everybody knows somebody they work with or someone in their family who has had a bad experience with a health insurance company in America. That is the reality we are facing today.

Mr. WHITEHOUSE. Mr. President, if I could ask the Senator to yield for a question, it would appear, then, that not only is there this subsidy that goes to the private insurance industry, funded by a tax on all other Medicare recipients, but those private insurance companies are actually doing their level best to try to pick out a disproportionately healthy Medicare-eligible population, so what we end up doing is not only paying more for Medicare Advantage but also for a healthier population. So it is a double subsidy.

Mr. DURBIN. Make it a triple whammy because the third impact, of course, is that the healthier people are not part of Medicare. Those left in Medicare are sicker and more expensive, so the government-run program ends up being more expensive because those private health insurance companies cherry-pick out the healthiest people they can find.

There are those who want to defend Medicare Advantage who think it is great that we would pay $170 billion in subsidies to these companies over a 10-year period of time. This bill moves us away from that and says if these private health insurance companies can't basically compete and match what government Medicare offers, then it is time for them to get out of the business and get out of the way. I don't see why in the world we are arguing about a subsidy for private health insurance companies when they already make so much money.

So I would at this point yield the floor. I know Senator HATCH has asked for an hour to speak on his motion. I believe it is a motion to commit. I yield the floor.

The PRESIDING OFFICER. The Senator from Utah is recognized.

Mr. HATCH. Mr. President, I thank my friend and colleague who has been making these extraordinary arguments on the Senate floor. I will spend a little bit of time chatting about those in just a minute.

MOTION TO COMMIT

Mr. HATCH. Mr. President, I send a motion to commit with instructions to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the motion.

The legislative clerk read as follows:

The Senator from Utah [Mr. HATCH] moves to commit H.R. 3590 to the Committee on Finance with instructions to report the same back to the Senate with changes that do not include cuts in payments to Medicare Advantage plans totaling −$120 billion.

Mr. HATCH. Mr. President, I always enjoy my colleague from Illinois. He is as good a populist speaker as we have in the Senate. No matter what comes up, he can talk about it.

I get a big kick out of him saying there are not any Republican bills. Well, there are six of them. You can get a hold of those bills. The problem is, we only have 40 votes, and we know it.

The fact is, the more I thought about it, I thought to myself, where are the printed bills that we always have on our desks? Where is the Democratic printed bill? I am sure it is somewhere. Usually when we debate any bill on this floor, we have the bill printed and put on our desks. Maybe it has been printed, but it isn't on our desks, and I think there is a good reason for it. It is 2,074 pages long. It is enough to make you barf.

When you stop and think about it, why do we need 2,074 pages when 85 percent of persons basically like the health insurance they have? The other 15 percent, if you break it down, you get down to about 7 million to 15 million people who need our help.

By the time you knock off those who work for a company that provides health insurance but they don't choose to take it because they would rather have the money or you take the approximately 11 million people who qualify for CHIP, the Child Health Insurance Program, or Medicaid, but aren't enrolled; or you take those who earn over $75,000 a year and just won't buy it but can afford it, or you take those undocumented workers or others who are legal aliens who for some reason do not have coverage, you get down to about 15 million people, at most. We can subsidize them, and we wouldn't have to throw our whole system out into the trash can—a system that 85 percent of the American people basically thinks is working relatively well for them.

It seems crazy to me. Why are we doing that? Fifty percent of the people in this country basically don't pay

Federal income taxes as we sit here. The upper 50 percent pay 97 percent of all income taxes. The bottom 50 percent pay about 3 or 4 percent, at the very most. Think about that. What are we going to do—go to 60 percent so that one side can keep the numbers here so they can stay in majority control? Are we going to get people to be more responsible for their own health care?

On top of it all, they want a government plan. Why do they want that? Medicare is the government plan. For all intents and purposes, it is very well-intentioned, but it has $38 trillion in unfunded liabilities as we sit here—mainly because the Federal Government is running it. If the State governments ran it and we had 50 State laboratories, I doubt seriously we would be in this terrible fix. We are saddling our children and grandchildren and great-grandchildren with tremendous debt. What is their answer? We are going to take $464 billion—almost $500 billion—out of Medicare, and we are going to put it towards making our health plan deficit neutral.

They have used every accounting and budgetary gimmick they can to get this plan below $1 trillion, because they charge taxes from the day it is passed, but the plan is not implemented for 4 years—until 2014. That way, they can try to indicate to the American people that they are bringing the cost of the bill in at under $1 trillion. That is a lot of money because today we are spending $2.4 trillion on health care, run primarily by the Federal Government—two-thirds of which is run by the Federal Government. I might add that there are estimates that $1.2 trillion of that $2.4 trillion is wasted money. Yet we are going to add another $2.5 trillion, which is what this bill really costs if you extrapolate it out over 10 years and not just from 2014 to 2020. We are going to spend another $2.5 trillion, if you extrapolate it out. No wonder the American people are so up in arms. They ought to be. We are going to be spending $5 trillion on health care if my friends are successful in what they are doing. They know we have 40 votes, at most.

I have been here a long time. Senator LUGAR and I are the most senior Republicans on the floor of the Senate. We came at the same time. I have to say that, having been here all these years, we have never really had a fiscally conservative majority in the Senate, except through great Presidential leadership—Reagan, Bush 1, even President Clinton on occasion, and Bush 2. We have always had enough liberals on our side to go with the liberal Democrats so we have never really had a fiscally conservative majority. It would take 60 votes to get this country under control, from a spending standpoint.

I appreciate the comments of my friend from Illinois about Medicare Advantage, but he is just plain wrong. Medicare Advantage has made a tremendous difference in the lives of almost 11 million Medicare beneficiaries. He failed to mention that the program has given choice to every Medicare beneficiary across the country, regardless of where they live. Medicare Advantage saves beneficiaries' dollars. Seniors have lower copayments, cost sharing, and deductibles through Medicare Advantage Programs. That is why many lower income seniors participate in the Medicare Advantage Program. Up to 25 percent of all seniors participate. Why? Because it works for them.

I was on the Medicare modernization conference committee. We came up with it because beneficiaries living in rural America did not have access to Medicare HMO plans before Medicare Advantage was created. If my friends will take the time to listen to my statement on Medicare Advantage, I believe they will find it insightful and it will rebut most everything they are saying.

Mr. President, the motion I just sent to the desk is to commit the Reid health care bill to the Finance Committee in order to eliminate the Medicare Advantage cuts of $120 billion contained in this legislation.

I know I mentioned this point over and over again, but it bears repeating. Throughout the health care debate, we have heard the President say he is not going to mess with Medicare. Unfortunately, that is not the case with the Reid bill we are currently considering. To be clear, the Reid bill cuts Medicare by $465 billion to fund a new government program. Unfortunately, our seniors and the disabled will suffer the consequences as a result of these reductions.

Throughout my Senate service, I have fought to strengthen, preserve, and protect Medicare. I think most Republicans have, in spite of what my colleagues say on the other side. Unless we are pouring money down the drain, they do not believe we are doing anything. Medicare is already in trouble today. The program faces serious challenges in the future. The Medicare trust fund will be insolvent by 2017. The program has more than $37 trillion in unfunded liability. The Reid bill will make this situation much worse.

Look at the cuts to Medicare. Hospitals, cut $134.7 billion in this bill. Where are they going to get that money? How are we going to keep hospitals going in the future? Hospices, cut $7.7 billion. Nursing homes, cut $14.6 billion. I have been to all kinds of nursing homes in this country, and they have a rough time. We are going to take over $14 billion from nursing homes, and they are critical to our senior citizens. For Medicare Advantage, $120 billion is coming out of the program. Home health agencies, $4.1 billion. So there is $135 billion from hospitals, $120 billion from Medicare Advantage, about $15 billion from nursing homes, more than $40 billion from home health care agencies, and close to $8 billion from hospice providers.

These cuts will threaten beneficiaries' access to care as Medicare providers find it more and more challenging to provide health services to Medicare patients. And what is their argument? They say it is the awful insurance companies causing these problems. No, it is the awful Federal Government causing these troubles. It is the awful bureaucracy and the awful Federal Government that dominates all of our lives. If this bill passes, ''Katy, bar the door.'' Our lives will be completely controlled by the Federal Government on one-sixth of the American economy.

Today, I want to focus my comments on the Medicare Advantage Program. It has been totally distorted by my colleagues, in my opinion—I am sure not intentionally. They would never do that.

By the way, here is the bill. This is not the printed version; this is the bill. It is no small bill. It is one of the largest I have seen in my time here.

Mr. President, I am strongly opposed to the deep cuts—$120 billion over 10 years—that the Reid bill would impose on the benefits of almost 11 million Medicare beneficiaries, Medicare beneficiaries who currently are enrolled in the Medicare Advantage Program.

While they knock Medicare Advantage, they are pushing people toward the AARP Medigap insurance program. AARP makes hundreds of millions and billions of dollars off senior citizens. It is small wonder that AARP supports this monstrosity of a bill. It is in their best financial interest.

As we consider the serious threat these cuts pose to seniors, I want to point out that during the Finance Committee markup this fall, we saw Senator BILL NELSON from Florida, and other Democrats, work to partially mitigate the impact of the bill's Medicare Advantage funding cuts. This effort, while taking very small steps, clearly demonstrated that a number of our Democratic colleagues recognize the value offered by Medicare Advantage plans and the danger of enacting the deep cuts proposed by the pending bill. Unfortunately, only a limited number of States would benefit from the Nelson amendment, so most Medicare Advantage beneficiaries are not protected from the cuts. But they recognize how important this program is.

I also recall that 6 years ago, when Congress enacted the Medicare Modernization Act, we intentionally provided new funding to stabilize the Medicare health plan program. This was one of the few issues on which there was strong bipartisan agreement during the 2003 Medicare debate. I was here. I was on the conference committee. I happened to bring about that Medicare Modernization Act. In fact, in June 2003, several of our colleagues, including the Senator from New York and Senator KERRY from Massachusetts—great Democrats—offered a bipartisan amendment on the Senate floor to provide additional funding for benefits under the Medicare Advantage Program. Why would they do that if it

is such a lousy program? Now, all of a sudden, it is a lousy program because they want the money to be used for a massive, new government-run program. Back then, they wanted additional money for Medicare Advantage, recognizing how important the program was.

Later that year, as the Medicare conference committee completed its deliberations, a bipartisan group of 18 Senators signed a letter urging the conferees to provide a meaningful increase in Medicare Advantage funding. This letter was signed by a diverse group of colleagues, including Democratic Senators such as DIANNE FEINSTEIN from California, CHRISTOPHER DODD from Connecticut, RON WYDEN from Oregon, FRANK LAUTENBERG from New Jersey, PATTY MURRAY from Washington, ARLEN SPECTER from Pennsylvania, MARY LANDRIEU from Louisiana, and MARIA CANTWELL, just to mention a few. It was bipartisan. They recognized how important this program was, and they recognized we were trying to solve major problems for people, especially in rural areas.

I think it would be worthwhile to reflect back on the 2003 debate and remember the reasons this issue inspired such strong bipartisan consensus. You don't hear it at all from that side at all—after the program has proven its efficacy and that it works. We supported the Medicare Advantage plan 6 years ago. It was the right thing to do for beneficiaries. The same logic holds true today.

We owe it to the beneficiaries to provide a strong, adequately funded program that provides them with high-quality health care choices. Every Medicare beneficiary can go into Medicare Advantage if they desire, under current circumstances.

During the Finance Committee's consideration of the Baucus health bill, I offered an amendment to protect extra benefits currently enjoyed by Medicare Advantage beneficiaries. Unfortunately, the amendment was defeated. In other words, the President's pledge assuring Americans they would not lose their benefits was not met by either the Finance Committee bill or the Reid bill currently being considered by the Senate.

Here is how supporters of the Finance bill justified the Medicare Advantage reduction: They argued that the extra benefits that would be cut, such as vision care and dental care for these poor people, reduced hospital deductibles, lower copayments and premiums, were not statutory benefits. They claim they were not statutory benefits offered in the Medicare fee-for-service program.

Therefore, those extra benefits did not count, although a quarter of the Medicare beneficiaries were getting them from Medicare. But try telling them that they did not count to a Medicare Advantage enrollee who has been receiving these additional benefits.

I want to talk about the differences between fee-for-service Medicare and Medicare Advantage. Because of the gaps in traditional Medicare, it is incumbent for most beneficiaries to buy a Medigap policy which wraps around the Medicare benefit. Guess who provides these Medicare policies, among others, but really in a big way. Why, the AARP.

On average, these policies cost a couple hundred dollars a month. In comparison, the average monthly premium in a Medicare Advantage plan is $54 in 2009. These plans also fill in the coverage gaps of Medicare.

Moreover, almost half of all Medicare Advantage beneficiaries are in plans that charge no monthly premium. Let me say that again. If you have to buy a Medigap policy for traditional fee-for-service Medicare, you will have to buy a policy that costs a few hundred dollars a month compared to Medicare Advantage plans which cost beneficiaries on average $54 a month in 2009. This is why several studies have shown that Medicare Advantage is one of the most popular choices for the low-income elderly because they do not have to buy a Medigap policy.

This week we have had Members on the other side of the aisle claim that Medicare Advantage is not part of Medicare. That is how far they have gone to distort the record. Again, I hope nobody was doing that intentionally and that it is a lack of knowledge about the Medicare program. Keep in mind, we have Members on the other side of the aisle who claim Medicare Advantage is not part of Medicare. It is absolutely unbelievable. I invite every Member making this claim to turn to page 50 of the 2010 Medicare handbook. It expressly says:

> A Medicare Advantage Plan . . . is another health coverage choice you may have as part of Medicare.

That argument has been not only fallacious but should never have been made. The bottom line is simple. If you are cutting Medicare Advantage benefits, you are cutting Medicare. I raised this point yesterday, but I want to raise it again.

Yesterday the distinguished Senator from Connecticut, my friend Senator DODD, mentioned that the bureaucrat-controlled Medicare commission will not cut benefits in Part A and Part B. Once again, my friends on the other side are only telling you half the story. So much for transparency. On page 1,005 of this bill I can hardly lift, it states in plain English:

> . . . include recommendations to reduce Medicare payments under C and D.

Let me translate that in English for everybody. That means the commission can cut Medicare Advantage, which is Medicare Part C, and the Medicare prescription drug benefit which is Medicare Part D.

Making sure that we take enough time to discuss a 2,074-page bill that will affect every American life and every American business is the sacred duty of every Senator in this Chamber. We must take the time to fully discuss this bill, and it is going to take some time, believe me.

I have heard several Members from the other side of the aisle characterize the Medicare Advantage Program as a giveaway to the insurance industry. Let me say a few words about the creation of Medicare Advantage.

I served, as I said, as a member of the House-Senate conference committee which wrote the Medicare Modernization Act of 2003. So did the distinguished Senator from Montana, Mr. BAUCUS. Among other things, this law created the Medicare Advantage Program. When conference committee members were negotiating the conference report, several of us insisted that the Medicare Advantage Program was necessary in order to provide health care coverage choices to Medicare beneficiaries.

At that time, there were many parts of the country where Medicare beneficiaries did not have adequate choices in coverage. In fact, the only choice offered to them was traditional fee-for-service Medicare, a one-size-fits-all government-run health program, which I might add, did not work well. By creating the Medicare Advantage Program, we provided beneficiaries with choice in coverage and then empowered them to make their own health care decisions as opposed to the Federal Government. We gave them the empowerment to make their own decisions. That is unique around here. There will not be any empowerment if this bill passes. In fact, there are almost 2,000 decisions that the Secretary of Health and Human Services has the authority to make. You might like the current Health and Human Services Secretary today, but what if a good conservative gets in that position? Of course, it is very difficult because a good conservative would be filibustered.

Today every Medicare beneficiary may choose from several health plans because of what we did through the Medicare Modernization Act of 2003. We should have learned our lessons from legislative changes made in the Balanced Budget Act of 1997 when we cut payments for Medicare HMOs. These plans collapsed, especially in rural areas, because Washington—our wonderful people here in Washington—decided to set artificially low payment rates. In fact, in Utah, all Medicare HMOs eventually ceased operations because they were operating in the red.

I fear history could repeat itself if we are not careful. During the Medicare Modernization Act conference, we fixed the problem. We increased reimbursement rates so that all Medicare beneficiaries, regardless of where they live, be it in Fillmore, UT, or New York City, had choice in coverage. Again, we did not want beneficiaries stuck with a one-size-fits-all government plan which, by the way, this monstrosity is.

Today Medicare Advantage works. Every Medicare beneficiary has access to a Medicare Advantage plan if they

so choose. One-quarter of them have so chosen, and it has worked amazingly well. Close to 90 percent of Medicare beneficiaries participating in the program are satisfied with their health coverage, but that could all change should this health care reform legislation currently being considered become law. Choice in coverage has made a difference in the lives of more than 10 million Americans nationwide. Beneficiaries in every State have benefitted from Medicare Advantage.

Let me show you some things here. Since this is very difficult to read on television, let me go through all these States. These charts show the number of Medicare Advantage beneficiaries in each state.

Alabama has 181,304 people on Medicare Advantage; Alaska, 462; Arizona, 329,157; Arkansas, 70,137; California, 1,606,193; Colorado 198,521; Connecticut, 94,181; Delaware, 6,661; the District of Columbia, 7,976. How about Florida—946,836, almost 1 million people on Medicare Advantage. Good reason. It works. Georgia, 176,090; Hawaii, 79,386; Idaho, 60,676; Illinois, 176,395; Indiana, 148,174; Iowa, 63,902 people enrolled in Medicare Advantage.

Let's proceed further. Kansas, 34,867 people enrolled in Medicare Advantage; Kentucky, 110,814; Louisiana, 151,954; Maine, 26,984; Maryland, 56,812; Massachusetts, 199,727; Michigan, 406,124; Minnesota, 284,101; Mississippi, 44,772; Missouri, 195,036; Montana, 27,592; Nebraska, 30,571; Nevada, 104,043; New Hampshire, 13,200; New Jersey, 156,607; New Mexico, 73,567; look at New York, 853,387; North Carolina, 251,738 people enrolled in Medicare Advantage who love the program; North Dakota, 7,633; Ohio, 499,819. Gee whiz, that is a lot of people who are satisfied with Medicare Advantage. Oklahoma, 84,980; Oregon, one of the most liberal States in the Union, 249,993; Pennsylvania, 864,040; Puerto Rico, even 400,991; Rhode Island, 65,108; South Carolina, 110,949—these are senior citizens—South Dakota, 8,973; Tennessee, 233,024; Texas, 532,242; my own State of Utah, 85,585; Vermont, only 3,966, but 3,000 people, 4,000 people in Vermont; Virginia, 151,942; Washington, 225,918; West Virginia, 88,027; Wisconsin, 243,443; and Wyoming, 3,942.

These are people who benefit from Medicare Advantage who would not like to lose their current health coverage.

This choice in coverage has made a difference in the lives of more than almost 11 million people, 11 million individuals nationwide and families who benefit from this program. The extra benefits I mentioned earlier are being portrayed as gym memberships as opposed to lower premiums, copayments, and deductibles.

Let me read some letters from my constituents. These are real lives being affected by the cuts contemplated in this bill. You should see some of the beautiful handwriting. Some of it is very shaky but beautiful, to me anyway.

From Cedar City, UT:

Senator Hatch, I am writing you to request your help in preserving our Medicare Advantage plans from being cut.

My Medicare Advantage plan provides me with benefits and savings that traditional Medicare did not provide.

I like my plan very much. It allows me my choice of Doctors, Hospitals and various specialists if needed.

I do not want to see a single national Health Care Plan.

I do not want cuts in Medicare Advantage Programs.

Senator Hatch, when you go to Washington, DC, please do not cut our Medicare Advantage Programs.

Vote to maintain our present system. Thank you for your service.

Sincerely. P.S.—I speak for my husband, too.

I bet.

Here is another one:

Honorable Senator Hatch: Please do not vote for any bill which would compromise my Medicare Advantage plan. I am 92 years old, and of necessity worked until I was 87, and have taken pride in being self supporting. I had to retire six and a half years ago because of pancreatic cancer. Amazingly, I recovered and live an active, useful life. My Medicare Advantage plan makes the difference between living with self respect and having to depend on others. Once again, I beg of you—don't deprive me of my self respect. Let me keep my Medicare Advantage plan. Sincerely.

Here is another one:

Dear Senator, we understand our President and Congress wants to eliminate the Medicare Advantage program for the elderly.

We were both on Blue Cross/Blue Shield program for several years, costing us hundreds of dollars each year. Since we joined the Medicare Advantage program it provides dental, fitness, vision, and full medical coverage. The cost of this program has saved us hundreds of dollars.

Please don't let them take this program from the elderly who are on low fixed incomes and will cause us further problems. We ask you for your support to save the Medicare Advantage program.

Here is another one:

Dear Senator Hatch, it has again been brought to my attention that the Administration is seriously considering cutting the funding to the Medicare Advantage program. I would like to encourage you to oppose these funding cuts because of the negative repercussions seniors and those with disabilities will suffer if they lose a program due to insufficient funding.

[Medicare Advantage] health plans give individuals the freedom to afford the care they need. The premiums and out-of-pocket costs are allowing recipients to save money on regular doctor visits as well as medication. These savings are essential for someone on a low fixed income like many of the individuals who participate in the program.

If Congress continues to cut the [Medicare Advantage] program, beneficiaries will not only be forced to pay higher premiums and higher out of pocket costs but will also lose the unique benefits that the [Medicare Advantage] health plans offer, such as disease management and preventive care, which reduce their daily discomforts and help them avoid unnecessary hospital visits.

What about this one?

As a retired voter in your state, I would ask you to please do all that you can to eliminate the proposed cut in Medicare Advantage funds in the proposed Senate bill. You have demonstrated the sensitivity for the elderly in our state. I hope you continue to take our needs as fixed income residents into consideration.

How about this?

I am greatly concerned about efforts to reduce benefits to the Medicare Advantage plans. I am a member of the Humana plan. It has been working for me because of the low premiums, low deductibles and co-pays, wellness and enhanced preventive benefits, and coordinated care and disease assistance programs. I have been unemployed for over a year now for several reasons, among them my age, I am sure. I received a monthly $527 social security check as my only income. I can survive only because I am living with my son and family. Please do what you can. Thanks so much.

Here is another one:

Dear Senator, I realize times are tough, but my medicare advantage plan through DMBA is a real blessing to me. I'd like to think that with all the talk of health care change, that plans that are working now would not be abandoned, or at least replaced with something as good, or better. Please think carefully and with sincere prayer, about the consequences to old retired people like me, before you vote on these issues. Thank you.

He recommends that I pray—which I do—about this.

Here is another one:

We like the Medicare Advantage Plan. Seniors need to have a choice in health care, and help in keeping that program. Medicare seems to always be cutting benefits for seniors. Have you talked to seniors lately? Doctors are not accepting anyone on Medicare and turn them away. This is an issue that needs to be addressed in health care. Keeping the Medicare Advantage Plan helps doctors accept a patient that has Medicare. Without an additional supplemental plan, seniors are in trouble with health care physicians. Please don't cause more suffering for seniors by cutting the Medicare Advantage programs.

Here is one:

Senator, we implore you to not allow the Medicare Advantage Plan to be compromised. As seniors, on fixed incomes, my husband and I find the monies, which have soared in 2009/2010 to allow us to participate in the Medicare Advantage Plan. Please see that this plan will remain available to all seniors with the same coverage. Sincerely.

Here is one:

As retired, fixed income, senior citizens we benefit by and rely on a Medicare Advantage Plan. We cannot afford the premiums that the Medigap insurance would cost if the Advantage Plans were not available. If not for our Advantage Plan, we would now be financially destitute because of the cost of my husband's health care these last 2 years. Without our Advantage Plan, we would not be able to afford yearly physical exams and preventive care. We also benefit from the Silver Sneakers exercise program as part of our plan. Senator Hatch, we urge you in any new health care plan, to: Keep Medicare Advantage Plans available; provide no government option/single payer; give no health care for illegals; fix the existing health system before adopting something new.

Here is another one:

Medicare Advantage Plans work great. Please don't let President Obama take them from us.

Here is another one:

We are Republicans from the State of Utah. Our concerns have to do with the

Medicare Advantage Program as offered currently to senior citizens and participants in Medicare. Part of this plan includes our participation in the Silver Sneakers Program which gives us the opportunity to use the local recreation center in Roy, UT. Our current Medicare Advantage Program covers the cost of the Silver Sneakers Program. Daily use of the Roy Recreation Center would be prohibitive to us if we had to carry the burden of the cost of this program. Thus, we encourage you to keep in mind these concerns as any health plan is proposed in Congress over the next few months. Thank you for your consideration in this matter. Please let us know your position in this matter.

How about this one?

I would like you to support the medicare advantage system and vote against any cuts to the advantage system. I am a member of the Humana Advantage program and very happy with the program. They provide additional benefits over Medicare with no additional cost, which is a direct financial advantage to seniors.

Let me just read one more. I have so many of these I could go on for hours, but let me just read one more.

I'm very concerned about the President's determination to do away with ''Medicare Advantage.'' My coverage is with DMBA, which is a nonprofit. It is my understanding DMBA actually pays some medical expenses over and above what Medicare authorizes. In addition, they administer the whole plan, which means I don't have to deal with Medicare directly. I feel that the amount of premium I pay to DMBA is worth these benefits. I'm willing to bet that Medicare costs will increase, if they have to start spending time dealing with seniors who currently have this kind of third party intervention. If there are really 10 million seniors who have ''Medicare Advantage,'' how can any of the members of Congress vote to eliminate it? Thanks, so much, for your time and efforts.

Well, I think that last letter kind of sums it up. How can anybody vote to do away with the Medicare Advantage Program?

Just to be clear, the SilverSneakers Program—which has been much maligned by the other side, who helped to enact the program, and who talk about prevention and care all the time—is one that has made a difference in the lives of many seniors because it encourages them to get out of their homes and remain active. It has been helpful to those with serious weight issues and valuable to women suffering with osteoporosis and joint problems.

In fact, I have received several hundred letters telling me how much Medicare Advantage beneficiaries appreciate the program. I would like to read a couple of those letters at this time, if I can. I will just read a few of them because there are many letters.

I recently have suffered from a heart attack and now receive treatment as a member of the Silver Sneakers. Being a part of the Silver Sneakers has helped my life immensely. The treatment I receive at the Silver Sneakers has readily increased my quality of life after my heart attack. I hope the funding for Silver Sneakers is not cut.

Well, that is Medicare Advantage. Here is the last I will read on the list.

I would like to express to you the need for the SilverSneakers program to continue. I have participated in this program for about 3 years now. I cannot begin to tell you the difference it has made since joining the program. I have not felt better health wise since joining the SilverSneakers program. My overall wellbeing both physically and mentally have improved. I go to the gym 3 times a week. I look forward to this physical activity. I feel physically better and my joints and body are in better shape than ever. I feel I have improved my immune system and go to the doctor less than when I did not participate in this program. I am retired with a fixed income and it would be difficult for me to have to pay for a gym membership if this program were to be eliminated. So I ask you to please consider keeping this program.

Look, the SilverSneakers Program is a prevention and wellness program, and almost all of us—if we are really honest about it—would admit that if we could get our seniors out there walking and exercising and doing the things that will help them to stay vibrant, alert, and physically well, it would save us billions of dollars. It is a very well-thought-out program, but it is a small part of Medicare Advantage. I thought I would cover it since it has been so maligned by some. If you read at least the HELP bill, there are a lot of provisions on wellness and prevention.

Well, in conclusion, I cannot support any bill that would jeopardize health care coverage for Medicare beneficiaries, and I surely believe if the bill before the Senate becomes law, Medicare beneficiaries' health care coverage could be in serious trouble.

I have been in the Senate for over 30 years. I pride myself on being bipartisan. I have coauthored many bipartisan health care bills since I first joined the Senate in 1977. As much as anyone in this Chamber, I want a health reform bill to be enacted this year. Every Republican does. But we want it to be bipartisan. We want it to be something both sides can support, such as the CHIP bill, which had a huge bipartisan vote. This is one-sixth of the American economy. If it doesn't get 75 to 80 votes, it is a lousy bill. I want it to be done right. History has shown if it is done right, it needs to be a bipartisan bill that passes the Senate with a minimum of 75 to 80 votes.

We did it on the CHIP bill and on Hatch-Waxman. We did it on a whole raft of bills in which I have been a major player. There has never been a bill of this magnitude affecting so many American lives that has passed this Chamber on an almost straight party-line vote, or maybe just a straight party-line vote.

The Senate is not the House. This body has a different constitutional mandate than the House. We are the deliberative body. We are the body that has, in the past—and should today—worked through these difficult issues to find clear consensus. True bipartisanship is what is needed. In the past, the Senate has approved many bipartisan health care bills that have eventually been signed into law. I mentioned a few: the Balanced Budget Act of 1997 which included the CHIP program—that was a Hatch-Kennedy bill—the Ryan White Act, I named the bill after Ryan White who died from AIDS, with his mother sitting right in the audience. I stood on the Senate floor and named it the Ryan White Act. And the Orphan Drug Act, the Americans with Disabilities Act, the Hatch-Waxman Act, which created the modern generic drug industry. These are just a few of the success stories. I could go through many, many others.

If the Senate passes this bill in its current form with a razor-thin margin of 60 votes or thereabouts, this will become one more example of the arrogance of power being exerted since the Democrats secured a 60-vote majority in the Senate and took over the House and the White House.

I dream someday of having the Republicans having 60 votes. I tell you one thing, I think we would finally have the total responsibility to get this country under control, and I believe we would be successful. There are essentially no checks or balances found in Washington today, just an arrogance of power with one party ramming through unpopular and devastating proposals one after the other.

Let me talk now about other negative impacts of this bill, at a time when we are in a terrible recession, with the current unemployment rate at 10.2 percent. And if you take away some of the part-time and some of the other statistics, we are at an effective 17 percent unemployment rate.

The Reid bill is a job killer. It has a disproportionate impact on small businesses. This 2,046-page bill contains nearly one-half trillion dollars in new taxes, fees, and penalties that will disproportionately affect small businesses, which are the job-creating engine and the lifeblood of our economy. Seventy percent of all jobs are created by the small business sector, and actually more if you really look at it.

According to a recent National Federation of Independent Businesses Survey, at least 50 percent of small businesses pay taxes at the individual level through owners that report income of more than $200,000 and will be hit hardest under the Democratic tax-and-spend plan with their mandate—their job-killing employer mandate—in this bill. This is small business. This is not the large corporate world. It is small business where most of the jobs are generated. Every dollar lost to new taxes on these businesses will be a dollar taken away from job creation.

The Reid bill includes a job-killing employer mandate. More specifically, it contains a $28 billion new tax penalty on employers for failing to provide coverage. Economists and CBO both agree that this will hurt employee wages and job creation. That is economists and CBO—the Congressional Budget Office. According to the Congressional Budget Office, although this new tax is levied on the employers, it is the ''workers in those firms who would ultimately bear the burden of those fees'' in the form of reduced compensation.

The Center on Budget and Policy Priorities has stated that the employer mandate will have a disproportionate impact on hiring practices for low- and moderate-income families. This is the most important segment in need of help.

The Reid bill increases the Medicare payroll tax. In fact, it imposes a $54 billion payroll tax increase at a time when we as a nation are struggling with an unemployment rate of 10.2 percent and an underemployment rate that I have been speaking about of 17.5 percent.

In addition, the Reid bill fails to lower premiums. Instead of lowering skyrocketing health care premiums for small businesses across the Nation, this $2.5 trillion bill, according to the Congressional Budget Office, will largely maintain the status quo of 5 percent to 6 percent yearly increases in premiums for small businesses. Why? A combination of heavyhanded regulations and a laundry list of new taxes on everything from health plans to prescription drugs, to medical devices which, according to the Joint Committee on Taxation, will simply be passed on to the consumers.

The Reid bill creates another brandnew Washington-run plan. This Washington-run plan comes at a time when families and businesses with private insurance are already paying as much as $1,800 a year more in premiums, which is nothing more than a hidden tax to make up for the underpayment by government programs such as Medicare and Medicaid to health care providers. It is no secret some doctors are not willing to take Medicare patients and even Medicaid patients because of the reimbursement rates, among others things, because of the bureaucracy—the bureaucratic problems. Creating another government-run program will only increase this hidden tax on families and small businesses to keep the private coverage of their choice, and I believe it is important for my colleagues to hear what businesses are saying about the Reid bill.

The National Federation of Independent Business, the premier small business organization in the country, says:

The Senate Bill Fails Small Business.

The U.S. Chamber of Commerce:

U.S. Chamber stresses disappointment with Senate health bill.

The National Association of Wholesaler-Distributors:

Wholesaler-Distributors say ''No'' to the Reid Health Bill.

The Small Business Entrepreneurship Council:

Small Business Group Says Reid Health Bill More of the Same: More Taxes, Mandates, Big Spending and Nothing to Help Lower Health Insurance Costs.

The Associated Builders and Contractors—great employers in this country:

ABC Critical of Senate Democratic Health Care Bill.

The National Association of Manufacturers:

NAM says Congress is Taking Health Care Reform in the Wrong Direction.

The Independent Electrical Contractors sent a letter of opposition to every Senator.

The International Franchise Association:

Franchise Businesses Oppose Senate Healthcare Reform Efforts.

There is a better way to handle health care reform. For months, I have been pushing for a fiscally responsible and step-by-step proposal that recognizes our current need for spending restraint, while starting us on a path to sustainable health care reform. There are several areas of consensus that can form the basis for sustainable, fiscally responsible, and bipartisan reform. We have a lot ideas over here for reforming the health insurance market for every American by making sure no American is denied coverage simply based on a preexisting condition; protecting the coverage for almost 85 percent of Americans who already have coverage they like by making that coverage more affordable. This means reducing costs by rewarding quality and coordinated care, giving families more information on the costs and choices of their coverage and treatment options, discouraging frivolous lawsuits, and promoting prevention and wellness measures.

By the way, the other side is not willing to do anything on tort reform that some estimate may be costing us as much, in unnecessary costs, as $300 billion a year.

Giving States flexibility to design unique approaches to health care reform. Utah is not New York and New York is not Utah.

As we move forward on health care reform, it is important to recognize that every State has its own unique mix of demographics and each State has developed its own unique institutions to address its challenges and each has its own successes. I believe in 50 State laboratories, where the States may be given the money by the Federal Government, but they solve their own problems with their own demographic needs and fitting their own demographic needs, rather than a one-size-fits-all big Federal Government program which is what this bill creates.

There is an enormous reservoir of expertise, experience, and field-tested reform in the States. We should take advantage of those experiences by placing States at the center of health care reform efforts so they may use approaches that best reflect their needs and challenges.

My home State of Utah has taken important and aggressive steps toward sustainable health care reform. The current efforts to introduce a defined contribution health benefit system and implement the Utah health exchange are laudable accomplishments. A vast majority of Americans agree that a one-size-fits-all Washington solution is not the right approach. That is what this bill is bound to foist on us.

Unfortunately, the path we are taking in Washington right now is to simply spend another $2.5 trillion of taxpayer money to further expand the role of the Federal Government. I do not know many people who believe that is what we should do. I wish the majority would take a step back, put their arrogance of power in check, and truly work on a real bipartisan bill that all of us can support, or at least a good percentage of us can support—not just one or two Republicans.

The first step in achieving bipartisanship is to support my motion to commit this bill so Medicare Advantage beneficiaries may keep the benefits they currently enjoy through Medicare Advantage plans. To me, it is only fair that the legislation we are currently considering hold true to the President's promise to the American people that if they like what they have they may keep it.

I urge my colleagues to support my motion to commit so that promise will also apply to Medicare Advantage beneficiaries who have benefitted greatly from what we did in a bipartisan way just a few years ago. I might add, some of these outside groups have a stake in killing it because they can make more money on senior citizens. It is not hard to see why they are behind this great big, huge 2,074-page monstrosity of a bill. No wonder they don't place this bill on every desk. Maybe they will. When they do, they will probably put two pages on one sheet so it will look a little bit smaller.

But it ought to be on every desk. We can even thumb through it while we are debating and while others are talking. Think what that would do for all of us Members of the Senate if we thumbed through some of the things we are doing to America. Remember, this is one-sixth of the American economy. We could wreck our country with this bill if we pass it. By passing it, we would turn our future 100 percent over to the Federal Government that has already put these two wonderful programs, Medicare and Medicaid, almost in bankruptcy. Those programs can be better, there is no question. But they are run by Washington, so naturally we are going to call on taxpayers, over and over again, to fund the excesses these bureaucracies in Washington impose on all of us.

The PRESIDING OFFICER (Mr. BEGICH). The time of the Senator has expired.

Mr. HATCH. I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island is recognized.

Mr. WHITEHOUSE. I know the Senator from Pennsylvania wishes to speak very shortly, and I will yield to him when he is present on the floor. But I did wish to react to two points that were made by the very distinguished Senator from Utah. I say that with true sincerity. He has been a friend to me since I have been in the

Senate. He sets a very valuable standard in this institution for collegiality and dignity and bipartisanship and scholarliness, and he comes from an extremely distinguished career, prior to his distinguished career in the Senate, as a lawyer, a leader of the Utah bar.

But I do think that, as easy as it is to make fun of a 2,074-page bill, the House bill, which is not significantly different in scale from this bill, was reviewed. If you look at the substantive language in it—in a bill, of course, there is a lot of language that simply connects things into place and is tables and indexes and things such as that. If you look at the actual language you would read if you were interested in the substance of the bill on the House side and do a word count on it, it has fewer words than a ''Harry Potter'' novel. I don't think it is too much to expect that Members of the Senate should be prepared to leaf through the equivalent of a ''Harry Potter'' novel when they are embarking on as significant an effort and endeavor as we are in reforming the health care system. I think it was about 256,000 words, if I am not mistaken. It is smaller print, admittedly, than a ''Harry Potter'' book because of the way in which the bill is presented in its traditional format. It is very few words per page, so it looks big and one can make very entertaining demonstrations with it on the floor. When you actually get down to reading it, it is about the same as plowing through—actually less than plowing through a ''Harry Potter'' novel, and I don't think that should be too much to expect.

I also suggest the reason for the lack of current bipartisanship on this bill might very well be the arrogance of power of the Democratic majority—it might be. But I would suggest the facts might also support a different hypothesis. If you look back at the history of the development of this bill, it began on a very bipartisan note. It began with Senator BAUCUS's ''prepare to launch'' program at the very beginning of the year, a full-day, bipartisan effort to begin to focus on the delivery system reform issues. It began with a bipartisan group negotiating in the Finance Committee. It began with a HELP Committee bill that allowed for 161, I believe was the number, Republican amendments in a very open and completely bipartisan process.

Then along came August and the townhall meetings and the beginning of the radicalization of the Republican Party. We heard, out of that process, charged buzz words such as ''death panels,'' ''socialized medicine,'' ''benefits for illegal immigrants,'' ''rationing of care''—all these words that incite and inflame passions but make no reasoned case and advance no helpful alternative.

We saw those words and those arguments presented with a crudeness and a venom that are frankly new to American politics; for example, the President portrayed with a Hitler mustache. I don't recall, for 8 years, President Bush ever being portrayed with a Hitler mustache. Poor President Obama comes in and within his first months people are running around America portraying him with a Hitler mustache because we want to reform health care.

Certainly, there are a great number of us who believed President Bush was less than truthful when he came and spoke to us about Iraq and other subjects, but nobody yelled out ''You lie.'' In President Obama's first appearance, he was heckled from the floor of the Congress of the United States.

This September, after the tea bag group and after the townhall death panel group had become active, 179 Republicans in the House of Representatives of the Congress of the United States voted to support their heckler comrade.

Something changed with the radicalization of the Republican Party, and I am not the only one to have noticed this. A very well-regarded Philadelphia columnist wrote recently of the Republican right:

> If they can get some mileage . . . nothing else matters.

The columnist went on to decry what he called ''the conservative paranoia'' and ''lunacy'' afoot in our national debate.

The editor of the Manchester Journal Inquirer editorial page wrote of the GOP, which he called ''this once great and now mostly shameful party,'' that it ''has gone crazy,'' that it is ''more and more dominated by the lunatic fringe,'' and that it has ''poisoned itself with hate.'' He concluded, they ''no longer want to govern. They want to emote.''

The respected Maureen Dowd of the New York Times, in her column eulogizing her friend, the late William Safire, lamented the ''vile and vitriol of today's howling pack of conservative pundits.''

A Nobel Prize-winning economist has said:

> The takeover of the Republican Party by the irrational right is no laughing matter. Something unprecedented is happening here, and it's very bad for America.

A well-regarded Washington Post writer with a quarter century of experience covering government and politics, married to a Bush administration official—we are hardly talking about commentary from the leftward fringe—has noted about the House health care bill and the arguments surrounding it ''the appalling amount of misinformation being peddled by its opponents.'' She called it a ''flood of sheer factual misstatements about the health-care bill.'' She noted that ''[t]he falsehood-peddling began at the top'' of the Republican Party. Her ultimate question was this:

> Are the Republican arguments against this bill so weak that they have to resort to these misrepresentations and distortions?''

Even the respected head of the Mayo Clinic has recently described the health care antics we have witnessed as ''mud'' and ''scare tactics.''

It is possible, as the distinguished Senator from Utah suggests, that the reason bipartisanship is elusive is because Democrats have been gripped by the arrogance of power. But as somebody who has been witness to intense efforts to try to recruit Republican support for this bill, the evidence at least as well supports the theory that something has happened to the Republican Party in the past months, as the radicalized Republican right has emerged and taken over and provoked all of these responses from respected, neutral, seasoned veterans observing the political scene. I suggest that is at least a possibility.

I would like to change topics for a moment, given that Senator CASEY is not present, and make an additional point that I believe merits mention. I will yield as soon as he appears to have arrived.

Mr. HATCH. Will the Senator yield for a second?

Mr. WHITEHOUSE. I am delighted to yield.

Mr. HATCH. I would like to have a few minutes to wrap up.

Mr. WHITEHOUSE. Of course. How long would the Senator wish?

Mr. HATCH. I think I can do it in less than 5 minutes.

Mr. WHITEHOUSE. I yield 5 minutes to the distinguished Senator from Utah right now.

The PRESIDING OFFICER. The Senator from Utah.

Mr. WHITEHOUSE. Would the Senator yield back for one moment?

Mr. HATCH. Surely.

Mr. WHITEHOUSE. I had the opportunity to be on the floor yesterday, and the time was all under agreement. My time was concluded, and I was leaving the floor. The Senator from Utah had the occasion to offer some very kind words about me. Because of the procedural posture we were in, I did not have the chance to reply or respond at that time. This is the first time we have been on the floor together since then, when I have had the chance to have the floor, and I do want to let him know how much I value what he had to say. I know there are very well-established standards of protocol here in which we say nice things about each other, but I felt that what he had to say was not just protocol but was sincere and heartfelt, and it really does mean a lot to me and is reciprocated on my part.

I think Senator HATCH brings enormous, as I said earlier, dignity, erudition, principle, collegiality—many good characteristics to the floor. He is a force for good in this body, and I am delighted to have him count me a friend.

I yield him the next 5 minutes.

Mr. HATCH. I thank my colleague. I appreciate the eloquence of my dear friend. I am going to find fault with some of the things he said, but I have to say I am grateful to have the distinguished Senator from Rhode Island with us. He is one of the great additions to the Senate, in my opinion, a

very good lawyer who has had tremendous experience in State government. It is amazing to me that he is supporting this awful bill, this monstrosity of a bill. But I can live with that. I have seen a lot of decent, honorable people be deceived by their desire on the Democratic side to continue to build the Federal Government at the expense of the States and everybody else. I will say this: I really enjoy my colleague. I have a lot of respect for him.

I have to take issue with his ''Harry Potter'' comments. Just think about that. I like the fact that the distinguished Senator from Rhode Island compares this bill here to a ''Harry Potter'' novel. That is, perhaps, pretty appropriate because both of them are what I consider to be works of fantasy and fiction. This thing has 14 pages as a table of contents alone. Notice how my voice goes up as I am holding it; it puts that much pressure on your speech diaphragm. I just wish it was as valuable and would be as valuable to the American people as the ''Harry Potter'' novels have been.

Let me say one last thing before I close and leave the floor. I appreciate my colleague. I appreciate his graciousness in all ways. We have worked closely together on the Intelligence Committee and the Judiciary Committee and in many other ways. I think he is one of the great additions to the Senate. In spite of his dogged determination in support of this awful bill, I still think greatly and very highly of him.

Let me make a few things clear to my Democratic colleagues. I am not a great believer that we should follow polls at all, but I think it is interesting to see what the American people are thinking. My colleagues seem to think that some of these people who did the tea parties and some of these other things are rightwing crazies. I know a lot of them. They are really good people. They are up in arms, and they are really upset. They are people from all walks of life. Some of them are very far right. Some of them are far left. The fact is, they are sincere. They feel what is going to happen here is a denigration of the country.

Unfortunately, I feel the same way. The more we rely totally on the Federal Government, the worse off this country will be. My colleagues love the Federal Government. I love it too. I would love to keep it in its place. It is much easier to control things when you control them through Washington. However, it is also a way of stifling good ideas if you do not have the best benefits of the 50 State laboratories that our Federalist system actually provides.

I noticed in a recent Gallup poll, 53 percent of the Independents are opposed to this bill. Gallup has been polling for years, is it not Republican or Democratic. These are Independents. Thirty-seven percent support the bill. These are not radical Americans, these are Independents. They are just tired of the tax-and-spend policies of Washington, DC. There are people in both parties who are guilty of pushing for those types of policies.

I have to say Democrats are much better at spending Federal dollars than Republicans in the sense that they spend a lot more of them. Democrats are not better in watching them either.

Even a Kaiser poll, which is anything but conservative, had 59 percent of the people in this country opposed to this bill.

If I were a Democrat, I would be a little concerned about the Independents. They are not crazies. They are not people who are out of line. And neither are these conservatives who are up in arms.

I recently met with a number of the tea party representatives in Utah. They are fiscal conservatives. They are very concerned. I also met with representatives of the so-called 912 Group. They are more concerned with social issues as well as economic issues. They are well-intentioned, well-thought-out people who are sick and tired of what is happening here in Washington. The only way they can really get their ideas heard is by raising cane about it. Frankly, I think they are right to do so.

We all better stop and take a look at these things and see if we can, as honest, decent Democrats and honest, decent Republicans, get together to come up with a bill that has broad bipartisan support of at least 75 to 80 Senators. I would like it to be more. But that is what we need to do. This current bill is not the way to get there.

I thank my colleague for his gracious remarks about me. I feel exactly the same about him. He is a good colleague, a wonderful attorney, and a great addition to the Senate. I intend to work with him in every way I can. I just think if he would just tell his side: We are going to sit down, we are going to work this out, I think we would get it done.

The PRESIDING OFFICER. The Senator from Rhode Island.

Mr. WHITEHOUSE. Mr. President, I see the distinguished Senator from Iowa as well as the distinguished Senator from Pennsylvania. Whichever one of them would like to proceed, I am prepared to yield. It looks as if it will be the distinguished Senator from Iowa.

I had the very great honor of serving on the HELP Committee during the time that the HELP Committee section of this bill was prepared. One of the most vital and important elements of this bill is its new focus on wellness and prevention to help Americans stay healthy so that it truly is health care and not just sick care, so that the medical establishment is not incented to add more and more tests and procedures because that is what they get paid for but won't have an e-mail contact or won't have a phone call to help talk a patient through something because they can't get reimbursed.

The potential value of wellness and prevention in this country is astonishing. It has been underinvested in because the people who are responsible for making those choices really don't get the benefit of them under our present perverse system.

The Senator from Iowa has shown great leadership. He is now chairman of the HELP Committee, but he certainly chaired, through the committee deliberations, the health and wellness portions. It was my honor to watch him in action and see the astonishing results he achieved.

I yield the floor to him and ask unanimous consent that at the conclusion of the remarks of the distinguished Senator from Iowa, the Senator from Pennsylvania, Mr. CASEY, be recognized.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Iowa.

Mr. HARKIN. Parliamentary inquiry: What rule are we under right now? How much time do we have? Are we under any time constraints?

The PRESIDING OFFICER. Under the previous order, the Senator controls the time until 8 p.m., approximately 15 minutes.

Mr. HARKIN. Mr. President, first I wish to thank my colleague for all the work he did in our committee. I am sorry he is not still on our committee. I wish he were. But a lot of the good work we have in our bill is due to Senator WHITEHOUSE's involvement in the development of this bill. He was a great member of our committee, and as the chairman, I sure wish he would come back. That is all I can say.

I say to the Senator, thank you for all the great work you did on this bill and especially all the wonderful work you did on getting us the public option that we had in our bill that was adopted by the House but also all the great work you did on making sure we had a robust prevention and wellness program in our bill. I have always said that the best way to bend the cost curve is to keep people healthy in the first place and keep them out of the hospital.

So I thank my colleague for all his great work on the bill.

Mr. WHITEHOUSE. Mr. President, I thank the chairman of the committee.

Mr. HARKIN. Mr. President, I would like to engage my friend from Pennsylvania in a little discussion on one part of the bill that was mentioned earlier today but really has not received much attention. I think there are some misconceptions about what it does. It is called the CLASS Act.

Basically, the CLASS Act is a bill that was championed by Senator Kennedy for many years. It has its genesis in the kind of convoluted system we

have now in how we provide for people who become disabled.

Either through their work, through an accident, through illness, or whatever, people become disabled. As you know, we have a portion of that under the Social Security system, disability insurance. But, in fact, it does not take care of any kind of long-term care. So Senator Kennedy, for many years, championed the idea of giving people the ability to set aside some money during their working years that would be sort of like Social Security. It would vest, and then, if, God forbid, they became disabled, they would then have a certain monthly income that would enable them to live in their own homes, live in their own communities, and to ease some of the burdens of their disability.

Before he passed away, Senator Kennedy talked to all of us on the committee about his dream and his hope that we would have this incorporated in our health reform bill.

Well, we did this in the HELP Committee. We brought it forward. We had it scored. We know exactly how it operates. As we will make clear, I am sure, in our colloquy, it is a program that can be paid for. It is voluntary, as we said. It will stand on its own two feet. It is not another entitlement program, as I heard someone say here earlier today. In fact, it has to be self-financing by the premiums people pay in during their working years. It is an affordable, long-term care program. Again, it will allow families to plan for any possibility of a chronic illness, without having the fear of being put in a nursing home. As I said, it is voluntary.

The CBO gave us a scoring on this that it was actuarially sound for 75 years—actuarially sound for 75 years. What that means is that the premiums paid in and the benefits paid out will be kept in proper alignment. It will be fully solvent.

Quite frankly, Mr. GREGG, the Senator from New Hampshire, on our committee, basically talked about this, and here is what he said:

> I offered an amendment, which was ultimately accepted, that would require the CLASS Act premiums to be based on a 75-year actuarial analysis of the program's costs. My amendment ensures that instead of promising more than we can deliver, the program will be fiscally solvent and we won't be passing the buck—or really, passing the debt—to future generations. I'm pleased the HELP Committee unanimously accepted this amendment.

Well, we did, and that is why I make the point that this is not another entitlement program, as was said here earlier today.

Even better, the CBO believes the CLASS Act will save Medicaid $1.4 billion in the first 4 years alone—$1.4 billion in the first 4 years alone—as a result of families who will be paying into and then using the CLASS benefit instead of Medicaid to similarly pay for the help they need to remain at home. That is really what people want. People want to stay in their own communities. They do not want to have to go to a nursing home.

The CLASS Act would provide money for assisted transportation, in-home meals, help with household chores, professional help getting ready for work, adult daycare, professional personal care. Now, will it pay for all those things? No, it will not pay for all those things, but it will give you enough of a basic support so that, coupled with other things, you would be able to stay at home and maybe even go to work. You may be disabled, but you may not be so disabled you cannot do some work; therefore, you need a little bit of help at home to get out in the morning and go to work or maybe you just need some personal assistance care that would enable you to stay in your own home rather than going to a nursing home.

So that is why this amendment is so important. It is voluntary, long overdue. I think it will begin to give people the peace of mind of knowing if they pay into this system, after it vests—after 5 years of vesting—they will then be able to access this program in case they get disabled.

Mr. President, I see my colleague and my friend from Pennsylvania is on the floor, a strong supporter of the CLASS Act and what we are trying to do here in terms of giving people the ability to maintain themselves if, God forbid, they should become disabled. I will be delighted to yield whatever time he needs to the Senator from Pennsylvania and engage in any colloquies he would like.

The PRESIDING OFFICER (Mr. BENNET). The Senator from Pennsylvania.

Mr. CASEY. Mr. President, I thank my colleague and friend, Senator HARKIN, who is now the chairman of the Health, Education, Labor, and Pensions Committee, taking over for Senator Kennedy. I know he feels an obligation not only to get this health care bill passed, but he also feels an obligation to the American people, as I think most people in this Chamber do, when it comes to health care. In particular, I commend Senator HARKIN for his great support for this legislation over a long period of time, and in particular for the CLASS Act.

One of the best moments in our deliberations this summer was when Senator HARKIN told a story about a relative of his. In a few moments, if he would tell that story, it brought home to me how important this program is and how it relates to the American people and what they do not have now, especially those Americans with disabilities.

When I step back and look at this program, a couple of things come to mind—a couple of themes, really. One is the word ''dignity,'' the dignity of work. So many Americans—by one estimate, 5 million Americans—under the age of 65 are living in our country who have long-term care needs, and there are over 70,000 workers with severe disabilities in the Nation today, who need daily assistance to maintain their jobs and their independence. So we are talking about a program which allows them to continue working with a disability. It allows them to overcome or surmount the barrier that is in front of them. Why would anyone not want to support this kind of a program, just in that brief description? But it is a lot more than that. It is about the dignity of work. It is about having independence, the ability to continue to work even with a disability. But it is also a very strong program for other reasons as well.

One is, as Senator HARKIN said so well—and Senator Kennedy led us on this program for many years, advocating for this approach—one important feature of this, as Senator HARKIN says, is it is voluntary. It is a voluntary, self-funded—self-funded—insurance program with enrollment for people who are currently employed. So we are talking about enabling and helping people to work and maintain their dignity and contribute to our economy. That is what we are talking about here. We are not talking about some government program we are going to create that no one knows what the results will be. We know exactly what this will do for millions of Americans.

Let me make a couple of points before I turn again to our chairman, Senator HARKIN.

First of all, there have been a lot of arguments made on the other side that we do not need this. Boy, I have not heard an alternative, which is true in a lot of the debates in the last couple of days. We hear a lot of criticism and critiques, some of them grossly inaccurate. But I am still waiting—still waiting—to hear an alternative, another idea. We do not hear much about that.

But the other side made a lot of points about cost and the budget and how you pay for programs such as this. Well, let's just turn to the first chart on my left.

Medicaid pays for a majority of long-term care in the United States of America. For long-term care, 40 percent of it is paid for by Medicaid. A lot of people think of the Medicaid Program, which I guess covers about 60 million Americans, roughly. We should think about long-term care. People do not often think about Medicaid as being connected directly to long-term care for older citizens, those who fought our wars, who worked in our factories, who raised our families, who gave us life and love, and all they ask for in the twilight years of their lives is a little help with their health care. Plenty of them are given skilled care in nursing homes, and for many of those who are in nursing homes, they have skilled care, and they have a good experience. For some, it is not so good. They would rather be able to stay at home. They would rather be able to have opportunities to be provided some help at home. So they want the kind of dignity I spoke about earlier. The same

is true of those who might be a lot younger but who have disabilities and want to continue working. They want to continue working.

Here is another way to look at this: Projected Medicaid spending on long-term services and supports is unsustainable because if nothing is done, Medicaid services for older citizens in America alone will rise by 500 percent by 2045. You do not have to be—I am certainly not an expert on how these costs are going up, but you do not have to be an expert to know that in the year 2000, you are at this level, and by the year 2045—not that far in the future—you are going to be over at above $200 billion. So Medicaid long-term services and support spending for those who happen to be aged 65 or older: $200 billion by 2045. So this is going up. This is when you do not do anything to meet a health care challenge. If we want to just keep this number going up, well, listen to the other side and just not enact any kind of a program.

Let me do one more chart, and then I will turn to Senator HARKIN for a discussion about this.

We hear a lot about spending and savings and how we are going to pay for health care. Well, if we want to pay for a part of this health care bill—and a big part of the challenge—we should enact the CLASS Act because Medicaid savings from this act, as you can see here: $1.6 billion just over the first 4 years. We are not talking about 10 years or 20 years or 40 years; we are talking about, in 4 years, you get $1.6 billion in savings—over the first 4 years of the implementation of the CLASS Act—starting in 2016.

So this is affirmative in the sense that it ensures people's dignity. It allows people to work even with a disability. And it is also fiscally responsible. And those who benefit from it are paying into it, and it is voluntary. No one has to do it. It is voluntary.

We have heard a lot of arguments, I say to Senator HARKIN, but I think we know from the work he did, working so many years with Senator Kennedy on these issues and working in the committee this summer, as one of our leaders—with Senator DODD chairing the hearings this summer—and now as the chairman of the committee, the Senator has been instrumental in getting not just this legislation moving forward but especially on the CLASS Act, and I am grateful for him taking on this responsibility. I want to get the Senator's sense of what he hears from people in Iowa and his own experience with why this is so essential for the American people.

Mr. HARKIN. I thank my friend and my colleague from Pennsylvania for laying out why this is so important, the fact that we are actually going to get savings for Medicaid from this. That is helping the States. That helps the States a lot. So we get a lot of bangs for the buck, as one might say, with the CLASS Act that we have in this bill.

I say to my friend from Pennsylvania I think one of the biggest concerns people have—they may not express it when they are younger, but once they start working and they start having a family and they see one of their friends, a relative, someone in their neighborhood, become disabled—and believe me, it happens in our neighborhoods, it happens to our friends—they see that and they wonder, Maybe but for the grace of God there go I, but what would I do if something like that happened to me? How would my family, my children function? Where would the money come from?

So to be able to have the peace of mind, to know there is a program whereby they can put some money aside every month, voluntarily, for 5 years, and then after that, they would then be able to access money if they got disabled—talk about a great insurance program. Talk about the peace of mind this would provide for people.

As I said, as we both have pointed out, this is actuarially sound for 75 years. So it seems to me that for all of these reasons, including the savings in Medicaid for the soundness of the program, but also for the peace of mind for people who are working, to know they now have a program, something they can access, that will provide them—again, I don't want to sell this for more than it is. This is not something that will make someone 100 percent whole from their earnings. We are not trying to tell people that. What this will give them is up to $75 a day to help them with all of the things I pointed out: maybe getting up, getting ready to go to work; maybe it is personal attendant services. It could be a whole host of different things that will enable them to live in their home, in their community, and, yes, maybe even be able to go to work every day.

My friend from Pennsylvania referred to the story I told earlier this summer, and I like to tell it because I think it illustrates what we are talking about here. I have a nephew, Kelly, my sister's boy. Well, he is not a boy anymore; he is an older man now, I guess you might say. He became disabled at a very young age, age 19, a severe paraplegic, but he was able to go to school, go to college. He was able then to live by himself in his own home. He had a van with a lift. He could get his wheelchair up there and punch the button and the doors would open and the thing would come down and he would get in the van. He had use of his hands. He could drive to work. He was able to start his own small business. But every morning he needed a nurse to come into the home, get him ready to go to work, get him up, get him going, get him out the door. Every night when he came home, he would stop and do some shopping on the way, come home to his own house where he lived, in his own community, among his family. His family was close by. They would have a nurse every evening do his exercises with him, keep his arms strong, do all of his other internal things that needed to be done, make sure he could get to bed. It happened every day. But because of that, he was able to live a full life, and he still is. Kelly is still an active man. But that was—gee, I am trying to remember now. I have to think. That was in 1979, 30 years ago. Kelly must be about almost 50 years old now. I never thought about that. I always think of him as a kid. But he was able to do that, and he has lived a full life. He has been able to work, live by himself, do all kinds of wonderful things.

How was he able to afford this? Was his family wealthy? Not a bit, not at all. In fact, his mother died shortly after the accident happened. My sister, who had breast cancer, died at an untimely, young age. But the way Kelly was able to do all this was because he got injured in the military. He got injured while he was onboard a ship off the coast of Vietnam. So the VA paid for all of this and is still paying for it—for his personal services—so that he can live by himself and get out the door and go to work. I have seen what that has done for him.

I thought to myself: Well, if we can do this for veterans, what about other people in our society who, through no fault of their own or through an accident or whatever, become disabled. I thought about how much Kelly was able to earn during his lifetime, the fact that he paid taxes, had his own business. You know, that was a pretty darn good deal for the taxpayers of this country.

In a small way, that is what we are trying to do here. That is what we are trying to do, to build a system for someone who gets injured, becomes disabled, has some support mechanisms so they can also live a full, rich, and happy quality life without having to go to a nursing home. That is what this is all about.

As I said before, I say to my friend, it has so much to offer. I can't imagine there would be any real opposition to this—voluntary, actuarially sound. It provides a stipend to help people if they become disabled.

I say to my friend from Pennsylvania it seems to me of all the things we have been discussing on this health reform bill so far, to me this is one of the most important. This is one of the most important parts of this health reform bill. We have never done it before. It is long overdue. It will be good for our families. It will be good for businesses. It will help our States because of the cutbacks and they won't have to pay so much into Medicaid.

I thank my friend from Pennsylvania for his strong support of this. I say to my friend Ted Kennedy: We are going to get it done. It is going to happen. We are not going to let this bill get through and go to the President without having this in it. It is going to be there. There is no doubt about it. We are going to make it work, just as the Veterans' Administration worked for my nephew Kelly.

I yield back to my friend from Pennsylvania. Actually, he asked me a question and I kind of got off a little bit there on telling my stories.

Mr. CASEY. I am glad the Senator told that story. For me, this summer, beginning to learn about the details of the CLASS Act, it was a way, through the life of the Senator's nephew, to be able to tell the story about why it was so important. I was thinking as you were talking about the program and the CLASS Act itself and your own personal story and why it makes so much sense.

Sitting here to my left on the floor is Connie Garner. She has worked for years on this legislation with Senator Kennedy. She would know better than I, and Senator HARKIN would know better than I. Ted Kennedy not only liked this and fought hard for this program, but he wasn't a guy who just liked interesting ideas, he wanted them to work.

Mr. HARKIN. That is right.

Mr. CASEY. There are times we will be talking about the Children's Health Insurance Program in this legislation. That is a program that had its origin in government, and there is a lot of government involvement in that program. I support it and will fight to the end of the Earth for it. This program, the CLASS Act, the program that results from the CLASS Act, is different. It is a hybrid. It is in many ways a creative way to provide these kinds of services for people with disabilities. It is not a government entitlement program. It is a program that doesn't confer rights or an obligation on government funding, nor does it affect the receipt of or eligibility for other benefits. It stands on its own financial feet, which is the point that Senator HARKIN made. Why wouldn't we do this?

This wasn't just dreamed up this summer. Senator Kennedy, Senator HARKIN, Connie Garner, and plenty of other folks were working on this for a lot of years. This is the result of years of work, not a couple of weeks or months. So they worked on this to get it right, and we have it right. It makes sense fiscally and it makes sense in terms of the dignity of people's work, the dignity of people able to stay in their home and be provided basic services.

All of our families are affected by this. At some point or another, you are going to have a loved one who wants to work but has a disability, maybe; or needs long-term care services and doesn't want to leave the home. Everyone is affected by that. There is not a Member of the Senate on either side who isn't going to be affected personally some day by this challenge. All we are saying is we have a way to make it a little easier for folks. As Senator HARKIN said, it doesn't solve all of the problems, but it helps provide the kind of services we should have the right to expect.

We have this figured out. Some of these things we can figure out because of all of the work that was done over many years. This program, this voluntary self-funded program is one way to do it. Senator HARKIN has been a leader on this and we are grateful for that leadership.

Mr. HARKIN. If the Senator would yield again to me, two other things. I am glad the Senator mentioned Connie Garner who again, with Senator Kennedy, has worked so many years on this, and has her own personal story to tell regarding this, a very poignant story. But I now want to thank Connie for all of her wonderful work on this and shepherding this through. She is probably sitting over there wishing we had said this and that, because we probably forgot something she knows better than we know. But we do our best, Connie. We do our best with what we have, anyway, to try to explain this. But I thank Connie for all of her great work and leadership in getting this to this point.

I wonder if I might impose upon the Senator, if I might—not digress but talk about one other part of the picture here we are talking about, in terms of covering people with disabilities. We have been talking about the CLASS Act, which is prospective. It looks ahead; it provides the mechanism whereby middle-class families can plan for the future possibility of an illness or a disability by putting this money away every month. We have talked about that. But one might ask the question: What about those who are disabled now? What is happening to them, the millions of Americans who are already living with a disability? Well, in 1990, we passed the Americans With Disabilities Act. We began to break down a lot of barriers in terms of people with disabilities and accessing daily living, accessing employment, transportation. But what happened was a few court cases started interfering with this. There was one court case in particular called the Olmstead decision 10 years ago. It came out of Georgia. It was a case in Georgia. It went to the Supreme Court. The Supreme Court said that based upon the Americans With Disabilities Act, a State had to provide the least restrictive environment for a person with a disability.

Well, this was wonderful because the only option for many people with disabilities right now is to go to a nursing home. In fact, our Federal laws are basically skewed toward putting people in nursing homes.

Let me explain. Right now, about the only support a person with a severe disability has is through Medicaid. As you know, through Medicaid you have to spend down until you become poor and then you get access to Medicaid. But under our laws, Medicaid must pay for you, if you are disabled, and then you qualify—they must pay for you to be in an institution or nursing home. They must. They have to pay for you. If, however, you are a person with a disability and you say: But I don't want to live in a nursing home; I would like to live—like my nephew Kelly—in my own house with my friends, in my own neighborhood, Medicaid doesn't have to pay for it, and in most cases it does not pay for that. In the vast majority of cases, it doesn't pay for that.

So their beginning movement was in the mid-1990s to provide for funding for individuals with disabilities so they can live in their own homes in the community and not have to go to the nursing home. Well, that bill never—it was called MCASSA, the Medicaid Community Attendant Support and Services Act.

I always like telling people, I say to my friend from Pennsylvania, while we sponsored it over in the Senate, the first sponsor of it in the House was the Speaker at that time who had taken over, and his name was Newt Gingrich. To this day, he is still supportive of that. A few years ago, I talked to him, and he was still a strong supporter of MCASSA. It later became the Community Choice Act. We could never get it enacted into law.

It is a part of this health care reform bill in this way: It provides that if a State implements this Community Choice Act, which would allow people with disabilities to live in the community rather than in a nursing home, it will then get a bump up. It will get a 6-percent increase in its Federal match for Medicaid.

As you know, now the Federal Government provides some and the State provides some for Medicaid. It is roughly 60/40. It varies a little, but that is roughly it, 60/40. Well, that means that a State now that would do this would not have to come up with its 40 percent; it would only have to come up with 34 percent. So it is an incentive for States to begin to implement the Supreme Court decision of over 10 years ago that people with disabilities have a right to live in the least restrictive environment. Again, Medicaid, right now, as I said, will provide only for nursing home care. States are obligated to pay for that. They must.

Again, this also is a part of what the elderly in this country are concerned about too. A lot of them say that if they become disabled, they don't want to go to a nursing home, but that is their only option under Medicaid. So that explains why the second biggest priority in poll after poll for seniors in this bill, after strengthening Medicare—which we do—is changes to the health care system that will allow them to get the help they need to stay at home rather than going to a nursing home.

Again, you might say, why is this so important? Well, a couple of stories. Two women who brought the Olmstead case, Lois Curtis and Elaine Wilson, when asked at a hearing what it changed for them, because they were no longer institutionalized, both spoke of things that we kind of take for granted: They had new friends. They could meet new people. They could attend family celebrations. They said:

We could make Kool-Aid whenever we wanted to. Simple things. They could go outside and walk in the neighborhood. They got a little dog, and they could walk the dog in the neighborhood—something they could not do in the nursing home. That is another part of the bill—very closely aligned with the CLASS Act, but it pertains to those people with disabilities right now.

We know, again, from data and statistics we have that by paying for personal care services and home care services—and you might say that is really expensive. But we know from data that we get three for one. In other words, for every one person in a nursing home, for what that costs, we can provide community and home-based services for three people. That is three people for every one in a nursing home. So in a way, yes, it costs money, but for every person we get out of a nursing home, we can pay for three living in the community. Again, that is not to mention the kind of quality of life I just mentioned.

This bill for the first time creates the community first choice option, which gives States an extra share of Federal money—6 percent—if they agree to provide personal care and services to all eligible people in their State—I mean those eligible for institutional care. If they provide that to them, then they get a bump up. And only by making personal care services available on an equal basis to all those eligible can we satisfy the promise of the Americans with Disabilities Act and really meet the Supreme Court mandate in the Olmstead decision.

I say to my friend from Pennsylvania, there are two aspects of the bill. One is the CLASS Act, which looks ahead and provides that peace of mind that people know they can have that access. Then we provide for people with disabilities who are living out there, fearful that the only thing that will happen to them is they will have to go to a nursing home. Now we are going to say to States: You provide community- and home-based services, and we will give you more money to do so through your Medicaid Program. Hopefully, with that, the States will begin to move more rapidly to fulfill the mandate of that Supreme Court decision.

I thank my friend for yielding me this time to explain that.

Mr. CASEY. Mr. President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. CASEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. CASEY. Mr. President, I ask unanimous consent that on Friday, December 4, after any leader remarks, the Senate then resume consideration of H.R. 3590 with debate only in order until 11:30 a.m., with no amendments, motions to commit, or any other motion, other than a motion to reconsider a vote, if applicable, in order during this period, except those that are currently pending, with the time after the leader time equally divided and controlled between the leaders or their designees, with the majority controlling the first portion of time.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. CASEY. Mr. President, I ask unanimous consent that the Senate proceed to a period for the transaction of morning business, with Senators permitted to speak therein for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

TRIBUTE TO JEFFERY D. RUPERT

Mr. REID. Mr. President, I rise today to recognize the work of Jeffery D. Rupert, who served as executive assistant to the U.S. Capitol Police Board from August 2003 to December 2009.

Pursuant to Public Law 108–7, section 1014(c) Congress established the position to act as a central point for communications and enhance the Police Board's work. In his capacity as the first executive assistant to the board, Mr. Rupert built the job from the ground up, developing policies, initiating procedures, and establishing an archival system which will serve as a historic chronicle of board security decisions.

Mr. Rupert contributed greatly to the safety and security of the Capitol Complex during his tenure, which included board support for two Presidential inaugurations, two dozen joint sessions of Congress, and other major special events and demonstrations.

Additionally, Mr. Rupert's regular daily duties enhanced the overall effectiveness and efficiency of the board's oversight activities. Whether he was coordinating a meeting or writing legal analysis, Mr. Rupert paid great attention to detail.

His more than 6 years of work were critical in supporting preparations for potential terrorist attacks and included a vast span of expertise in law enforcement, safety, and security issues. He served the USCP and the Capitol Police Board honorably in the aftermath of the ricin attacks.

Mr. Rupert served as a liaison with other congressional and executive branch entities to include the Department of Homeland Security, the Federal Bureau of Investigation, the Central Intelligence Agency, the Department of Defense, and many other agencies. As a liaison, Mr. Rupert provided information concerning national level issues including continuity of government and continuity of operations for the U.S. Congress. His personal and professional contacts ensured seamless sharing of vital intelligence, and the Capitol community was well served during his stewardship.

I understand Jeff has accepted a high-ranking position at the Pentagon. On behalf of the entire Senate, I wish Jeff the very best in his future endeavors and offer him heartfelt thanks for his service to Congress and the American people.

HONORING OUR ARMED FORCES

PRIVATE FIRST CLASS KIMBLE A. HAN

Mr. HATCH. Mr. President, I rise today to pay tribute to PFC Kimble A. Han who made the ultimate sacrifice for his country on October 23, 2009, in Afghanistan. According to initial reports, Private First Class Han died of injuries sustained when an improvised explosive device detonated near his vehicle.

Private First Class Han was assigned to the 569th Engineer Company, 4th Engineer Battalion, Fort Carson, CO.

Private First Class Han enlisted in the Army in January of 2008 and by December was assigned to the combat engineers. He exhibited an astounding sense of devotion to duty in service to our great Nation. He received numerous recognitions, medals and ribbons for his service, including the National Defense Service Medal, the Afghanistan Campaign Medal with Campaign Star, the Global War on Terrorism Service Medal, Army Service Ribbon, Overseas Service Ribbon and Combat Action Badge. As a result of his heroic service, Private First Class Han was posthumously promoted to specialist. The selfless courage Kimble displayed in the service to our country will not be forgotten. We are forever in his debt.

Mr. President, let us not forgot the sacrifice of PFC Kimble A. Han. I am filled with deep gratitude for his service and pray for his family and friends throughout this difficult time. I know that I am joined by all my colleagues in the Senate in mourning the loss of PFC Kimble A. Han, our Nation's protector and hero.

SERGEANT JAMES MICHAEL NOLEN

Mr. President, I rise today to pay tribute to SGT James Michael Nolen who was killed in the line of duty on November 23, 2009, in Zabul, Afghanistan. Sergeant Nolen sustained fatal wounds when enemy forces attacked his vehicle with an improvised explosive device.

SGT James Nolen served with the 2nd Battalion, 508th Parachute Infantry Regiment, 4th Brigade Combat Team, 82nd Airborne Division, Fort Bragg, NC.

Sergeant Nolen truly exemplified the qualities of a dedicated soldier and hero. A fellow paratrooper conveyed that ''Sergeant Nolen was a true soldier. Nothing could take away from his warm personality. His caring smile and willingness to help others were his most identifiable features.''

James exhibited an astounding sense of devotion and duty to our great Nation. He received numerous recognitions, medals and ribbons for his service including the Bronze Star Medal, the Purple Heart Medal, the Army Commendation Medal, the Army Achievement Medal, the Army Good Conduct Medal, the National Defense Service Medal, the Global War on Terrorism Service Medal, the Army Service Ribbon, the Overseas Service Ribbon, the NATO Medal, the Combat Infantryman Badge and the Basic Parachutist Badge.

Mr. President, I express my deepest appreciation for the selfless dedication this soldier proudly exhibited in service to our country. He courageously put himself in harm's way to defend us, and for that we owe him an infinite debt of gratitude. I offer my deepest condolences and prayers for James' family and friends during this difficult time. I know that I am joined by all my colleagues in the Senate in mourning the loss of SGT James Michael Nolen, our Nation's protector and hero.

NOMINATION OF JACQUELINE NGUYEN

Mr. BEGICH. Mr. President, I want to comment today on the confirmation earlier this week of the Honorable Jacqueline Nguyen to be judge on the U.S. District Court for the Central District of California. Unfortunately, I was delayed in my return from Alaska, and I was unable to be here for the vote. Had I been here, I would have proudly cast my vote along with the rest of my Senate colleagues to confirm this highly qualified and well-respected jurist. Upon her confirmation, Judge Nguyen made history by becoming the first Vietnamese-American to serve as a U.S. district court judge in U.S. history.

I applaud the judge's unanimous confirmation by the Senate as an example of what we do all too infrequently, I am afraid—recognizing a public need and to acting appropriately and expeditiously to address it. I commend the President for heeding the recommendation by our colleagues from California and nominating a woman of obvious talent. The President nominated Judge Nguyen, I am sure, because he perceived in her a combination of the education, experience, and temperament appropriate for a life-tenured position on the federal bench. Her unanimous ''well qualified'' rating from the American Bar Association's Standing Committee on the Federal Judiciary, earned after an 18-year career in the law, including nearly 7 years as a California Superior Court judge and roughly the same amount of time as an assistant U.S. attorney in the same district in which she will now serve as a Federal judge, would seem to be completely justified. I have little doubt that Judge Nguyen will be an outstanding Federal judge.

As impressed as we all should be with her qualifications, I believe we can all look at the details of Judge Nguyen's life as a truly great and quintessential American story. Born in Da Lat, Vietnam, Judge Nguyen and her family were able to escape the approaching North Vietnamese and Viet Cong armies, departing Saigon in 1975 on a crowded helicopter as gunfire could be heard in the background. The Nguyen family was part of the great wave of Vietnamese immigrants who left their homeland to escape the Communist takeover. After stops in refugee camps in the Philippines and on Guam, the Nguyens made their way to California, spending several months living in a tent on the grounds of the Marine base at Camp Pendleton. The Nguyens eventually settled in La Crescenta. The judge, her siblings, and their mother cleaned dental offices after school and at night, while her father studied to be a computer programmer and worked in a gas station at night and on weekends. Eventually, her parents purchased a doughnut shop in North Hollywood. Judge Nguyen says she often did her homework during high school between shifts at the doughnut shop and also worked there while she was earning her degree from Occidental College. She would ultimately earn her law degree from UCLA.

I do not know Judge Nguyen, but I am impressed by her accomplishments and the drive she and her family have shown in coming to this country and embracing the opportunities the United States offers it citizens. I recognize in her story the same drive and love of country that I have seen among the Vietnamese-American citizens of Alaska. The United States is a nation made great in part by its diversity. I personally take pride in serving alongside our first African-American President, and at the same time as our first Vietnamese-American Federal judge. Still, as much as the confirmation of this highly qualified woman is an example of the possibilities available to all Americans, I cannot help but believe it is being hailed today as a point of immense pride by the Vietnamese-American community in my home State of Alaska, in Judge Nguyen's State of California, and all across this country. I extend the judge, and the Vietnamese-American community, my sincere congratulations.

STEM EDUCATION

Mr. KAUFMAN. Mr. President, a few weeks ago the Department of Education released application guidelines for the Race to the Top competitive grant program. I am very encouraged that these guidelines include a competitive preference for science, technology, engineering, and mathematics—or STEM—education. I commend the Department for its foresight.

Throughout the year, I have spoken many times about how important a focus on science and engineering is to our continued economic recovery. Engineers and scientists have always been the world's problem-solvers. They will help us to solve the challenges of clean water; lifesaving cures for cancer and disease; clean, renewable petro-free energy; affordable-health care; and environmental sustainability.

Yet, if we are to tackle these immense challenges, we can no longer wait to begin training our Nation's future STEM professionals until after they leave the K–12 education pipeline. That is why I am so pleased that the Race to the Top grant application emphasizes STEM education. This is just the kind of attention STEM education needs.

The Race to the Top fund is designed to reward States that have been successful in raising student achievement and have superior plans to accelerate education reform. State grant applications must, of course, focus on certain core education reform areas. However, an emphasis on STEM education is considered a competitive preference priority worth 3 percent of a State's application score. It is the only competitive preference in the Race to the Top application guidelines. Applicants will earn all or none of the designated points, thereby truly rewarding sound initiatives.

To meet this priority, each State must offer a rigorous course of study in STEM education. They are encouraged to collaborate with industry professionals, universities, research centers, museums, and other STEM-focused community partners. Additionally, each State must have a plan for preparing and assisting teachers in integrating STEM throughout the curriculum. This includes offering applied learning opportunities and relevant instruction for students.

There are some successful STEM education programs already in operation throughout the country. A study released by the National Academy of Engineering in September highlighted a handful of K–12 engineering curriculum projects. Other education-based initiatives are also spurring interest among our youth. For example, there is a remarkable afterschool program in Wilmington, DE, that I recently spoke about here in the Senate. It inspires high school students to pursue careers in STEM fields by teaching them how to build robots. It is a great program. All too often, though, these types of opportunities have not been available to all of our Nation's students. The Race to the Top grants will bring more opportunities to more students.

Perhaps the most important component for meeting this grant priority is that States' plans must prepare more students to pursue college majors and careers in STEM. They must also specifically address the needs of women and underrepresented minorities. The United States cannot maintain its position as a technological leader nor can we solve the problems we face without a diversity of perspectives and participation.

Women constitute about half of the students in our higher education system about half of the overall workforce, but they comprise only slightly more than 12 percent of the science and engineering workforce. African Americans hold only 4.4 percent of science and engineering jobs, Hispanics just 3.4 percent. We can, and must, do better, and the Race to the Top application guidelines are a step in the right direction.

Over $4 billion is available for competitive grants in the Race to the Top program. This is an unprecedented level of discretionary funding for the Department of Education, and States nationwide will be pulling out all the stops to earn their share of the pie. Many States working months ago to put the correct conditions in place to apply for funds.

Moreover, the ''Educate to Innovate'' campaign was recently launched by President Obama. This campaign is a nationwide effort of private companies, universities, foundations, nonprofits, and science and engineering societies—working with the Federal Government—to improve student performance in STEM subjects. As part of this effort, business leaders and nonprofits will be joining forces to identify and replicate successful STEM programs across the country. For example, Time Warner Cable and the Coalition of Science After School are creating an online directory of STEM afterschool programs. Other STEM organizations will be teaming up with local volunteers to host National Lab Days, and President Obama announced an annual science fair at the White House. This type of public-private collaboration is just the kind of action we need to bolster STEM education.

I sincerely hope the competitive preference for STEM education in the Race to the Top application, coupled with the ''Educate to Innovate'' campaign, will spur the kind of investment and attention in STEM education that I believe all of our students deserve. Our country is counting on these future scientists and engineers.

TRIBUTE TO MAJOR LAMONT ATKINS

Mr. AKAKA. Mr. President, I wish today to recognize MAJ Lamont Atkins of the U.S. Air Force, who has been my military legislative fellow for the past year.

Lamont is a proud alumnus of the University of Alabama, where he earned a bachelor of science in management information systems, and an avid fan of Alabama's Crimson Tide football team. He also holds a masters of arts in computer resources and Information Management from Webster University. With over 11 years in the military, Major Atkins brought a wealth of knowledge and experience to my office. He has excelled in every previous assignment and has received numerous commendations, including several Officer of the Year awards.

While Major Atkins' primary duty was to assist my military legislative assistant on defense and veterans' issues, he also made significant contributions in other areas, including banking, judiciary, health, and education issues. Major Atkins prepared for Senate Army Caucus meetings, researched banking issues, and wrote memos on a variety of topics. Lamont performed beyond expectations. His flexibility and willingness to go the extra mile greatly benefited our office.

During Lamont's tenure, we transitioned from one military legislative assistant to another. Lamont's assistance was crucial to ensuring a smooth transition, and was key in bringing the new military legislative assistant up to speed on my initiatives.

Major Atkins was stationed at Hickam Air Force Base prior to his assignment at the Pentagon. The opportunity of experiencing firsthand the unique needs of the constituents of Hawaii was instrumental to Lamont's success on our staff, and Lamont displayed the aloha spirit daily.

I also extend my sincere aloha to Lamont's wife Karonica and their children, Lamont Junior and Kendall, whom my staff and I have also had the pleasure of getting to know during Lamont's time in my office. I extend my heartfelt aloha and utmost appreciation to Major Atkins for his service to the great State of Hawaii, to the Senate, and to our Nation. My staff and I will miss him dearly. I wish Lamont and his 'ohana the very best in their future.

ADDITIONAL STATEMENTS

RECOGNIZING MILL CREEK ELEMENTARY

● Mr. BOND. Mr. President, on behalf of my fellow Missourians, I extend my warmest congratulations to Mill Creek Elementary School in Columbia, MO.

Mill Creek Elementary is celebrating 20 years of dedication to educating its students. When Mill Creek opened in 1989, it served 486 students. Now, the school is home to 90 faculty and staff members and 760 students.

Mill Creek Elementary has educated and advanced thousands of students over the years. The faculty and staff have helped students to develop the knowledge and skills that will serve them throughout their lives so they may contribute to their communities one day.

At Mill Creek, students pledge to be respectful of themselves and others, responsible for their own learning and behavior, and resourceful problem-solvers. These standards are known as the 3 R's: respect, responsibility, and resourcefulness. Mill Creek hopes to instill these standards within its students so they will use them not just at school but also in their homes and their communities.

Public education is strengthened when schools have the support of the local community. KMIZ–17, Rolling Hills Veterinary, Columbia Insurance Group and Boulevard Bank have all stepped forward to be involved at Mill Creek through the Partners in Education program. These businesses provide time and support to students through mentoring, hands-on lessons and even a school weather station.

Strong parental involvement also leads to school success. Mill Creek benefits tremendously from the countless PTA and volunteer hours donated by family members and community leaders each year.

Mill Creek Elementary has been committed for over 20 years to providing a high quality education to its students and preparing them to be leaders in their community. Parents, students, teachers and staff can all be proud of their accomplishments.

Congratulations to the Cougars!●

RECOGNIZING THE BRIDGEVILLE VOLUNTEER FIRE DEPARTMENT

● Mr. CARPER. Mr. President, today I offer my congratulations to Chief Jack Cannon and President Allen Parsons and the entire company as the Bridgeville Volunteer Fire Department celebrates 100 years of service. The success of the fire company is a tribute to the many dedicated men and women who not only have served in the Bridgeville Fire Company, but have served the entire Bridgeville community in any number of ways, as well.

Since 1909, the members of the Bridgeville Volunteer Fire Company have protected the property and residents of this historic community. The fire company has reached many milestones throughout the years, including equipment upgrades, the formation of the Ladies Auxiliary, and moves to larger stations to accommodate growth and expansion. As it currently stands at 60 volunteer members and 2 professional emergency medical technicians, the Bridgeville Volunteer Fire Company represents a standard of excellence, answering over 300 fire calls and 800 ambulance calls annually, night and day in all kinds of weather.

Delaware's firefighters are dedicated and caring professionals who willingly put themselves at risk to protect the lives and property of their neighbors. We are all sincerely grateful for their continuing service. The hard work and dedication of these devoted volunteers is an inspiration to all. Moreover, the Bridgeville Volunteer Fire Company has crafted a tradition of superior and selfless service.

I again congratulate the members on this momentous anniversary and look forward to hearing of their continued success for another hundred years and beyond.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mrs. Neiman, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGE FROM THE HOUSE

At 11:22 a.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 320. An act to amend the National Manufactured Housing Construction and Safety Standards Act of 1974 to require that weather radios be installed in all manufactured homes manufactured or sold in the United States.

H.R. 515. An act to prohibit the importation of certain low-level radioactive waste into the United States.

H.R. 1242. An act to amend the Emergency Economic Stabilization Act of 2008 to provide for additional monitoring and accountability of the Troubled Asset Relief Program.

H.R. 2873. An act to provide enhanced enforcement authority to the Securities and Exchange Commission.

H.R. 3634. An act to designate the facility of the United States Postal Service located at 109 Main Street in Swifton, Arkansas, as the ''George Kell Post Office''.

H.R. 3963. An act to provide specialized training to Federal air marshals.

H.R. 3980. An act to provide for identifying and eliminating redundant reporting requirements and developing meaningful performance metrics for homeland security preparedness grants, and for other purposes.

The message also announced that the House has agreed to the following concurrent resolutions, in which it requests the concurrence of the Senate:

H. Con. Res. 129. Concurrent resolution congratulating the Sailors of the United States Submarine Force upon the completion of 1,000 Ohio-class ballistic missile submarine (SSBN) deterrent patrols.

H. Con. Res. 197. Concurrent resolution encouraging banks and mortgage servicers to work with families affected by contaminated drywall and to consider adjustments to payment schedules on their home mortgages that take into account the financial burdens of responding to the presence of such drywall.

At 5:52 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 3570. An act to extend the statutory license for secondary transmissions under title 17, United States Code, and for other purposes.

H.R. 4154. An act to amend the Internal Revenue Code of 1986 to repeal the new carryover basis rules in order to prevent tax increases and the imposition of compliance burdens on many more estates than would benefit from repeal, to retain the estate tax with a $3,500,000 exemption, to reinstitute and update the Pay-As-You-Go requirement of budget neutrality on new tax and mandatory spending legislation, enforced by the threat of annual, automatic sequestration, and for other purposes.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 320. An act to amend the National Manufactured Housing Construction and Safety Standards Act of 1974 to require that weather radios be installed in all manufactured homes manufactured or sold in the United States; to the Committee on Banking, Housing, and Urban Affairs.

H.R. 515. An act to prohibit the importation of certain low-level radioactive waste into the United States; to the Committee on Environment and Public Works.

H.R. 2873. An act to provide enhanced enforcement authority to the Securities and Exchange Commission; to the Committee on Banking, Housing, and Urban Affairs.

H.R. 3570. An act to amend title 17, United States Code, to reauthorize the satellite statutory license, to conform the satellite and cable statutory licenses to all-digital transmissions, and for other purposes; to the Committee on the Judiciary.

H.R. 3634. An act to designate the facility of the United States Postal Service located at 109 Main Street in Swifton, Arkansas, as the ''George Kell Post Office''; to the Committee on Homeland Security and Governmental Affairs.

H.R. 3963. An act to provide specialized training to Federal air marshals; to the Committee on Commerce, Science, and Transportation.

H.R. 3980. An act to provide for identifying and eliminating redundant reporting requirements and developing meaningful performance metrics for homeland security preparedness grants, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

The following concurrent resolutions were read, and referred as indicated:

H. Con. Res. 129. Concurrent resolution congratulating the Sailors of the United States Submarine Force upon the completion of 1,000 Ohio-class ballistic missile submarine (SSBN) deterrent patrols; to the Committee on Armed Services.

H. Con. Res. 197. Concurrent resolution encouraging banks and mortgage servicers to work with families affected by contaminated drywall and to consider adjustments to payment schedules on their home mortgages that take into account the financial burdens of responding to the presence of such drywall; to the Committee on Banking, Housing, and Urban Affairs.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–3855. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; SOCATA Model TBM 700 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0557)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3856. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Airbus Model A318–111, –112, A319, A320, and A321 Series Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2008–1215)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3857. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Saab AB, Saab Aerosystems Model SAAB 340A (SAAB/SF340A) and SAAB 340B Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0134)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3858. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; PIAGGIO AERO INDUSTRIES S.p.A Model PIAGGIO P–180 Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0699)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3859. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Hawker Beechcraft Corporation (Type Certificate previously held by Raytheon Aircraft Company) Models 1900, 1900C, and 1900D Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0165)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3860. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Airworthiness Directives; Bombardier Model CL–600–2B19 (Regional Jet Series 100 & 440) Airplanes'' ((RIN2120–AA64)(Docket No. FAA–2009–0310)) as received during adjournment of the Senate in the Office of the President of the Senate on November 24, 2009; to the Committee on Commerce, Science, and Transportation.

EC–3861. A communication from the Regulatory Analyst, Grain Inspection, Packers and Stockyards Administration, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Poultry Contracts; Initiation, Performance, and Termination'' (RIN0580–AA98) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3862. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Apricots Grown in Designated Counties in Washington; Decreased Assessment Rate'' (Docket No. AMS–FV–09–0038; FV09–922–1 FIR) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–3863. A communication from the Deputy Secretary of Defense, transmitting the report of (12) officers authorized to wear the insignia of the grade of major general in accordance with title 10, United States Code,

section 777; to the Committee on Armed Services.

EC–3864. A communication from the Director of Defense Procurement and Acquisition Policy, Department of Defense, transmitting, pursuant to law, the report of a rule entitled ''Defense Federal Acquisition Regulation Supplement; Definitions of Component and Domestic Manufacture'' (DFARS Case 2005–D010) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Armed Services.

EC–3865. A communication from the Under Secretary of Defense (Acquisition and Technology), transmitting, pursuant to law, an annual report on the Mentor-Protégé Program for fiscal years 2007 and 2008; to the Committee on Armed Services.

EC–3866. A communication from the Regulatory Specialist, Office of the Comptroller of the Currency, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Risk-Based Capital Guidelines; Capital Adequacy Guidelines; Capital Maintenance; Capital-Residential Mortgage Loans Modified Pursuant to the Home Affordable Mortgage Program'' (RIN1557–AD25) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3867. A communication from the Regulatory Specialist, Office of the Comptroller of the Currency, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Final Model Privacy Form Under the Gramm-Leach-Bliley Act'' (RIN1557–AC80) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3868. A communication from the Assistant to the Board of Governors, Federal Reserve System, transmitting, pursuant to law, the report of a rule entitled ''Truth in Lending—Interim Final Rule; Request for Public Comment'' (Regulation Z; Docket No. R–1378) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–3869. A communication from the Office Manager, Centers for Medicare and Medicaid Services, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Medicaid Program: State Flexibility for Medicaid Benefit Packages and Premiums and Cost Sharing'' (RIN0938–AP72 and RIN0938–AP73) received in the Office of the President of the Senate on November 30, 2009; to the Committee on Finance.

EC–3870. A communication from the Chairman of the U.S. International Trade Commission, transmitting, pursuant to law, a report relative to the Commission's Strategic Plan covering the period from fiscal year 2009 through fiscal year 2014; to the Committee on Finance.

EC–3871. A communication from the President of the United States, transmitting, pursuant to law, a report relative to an alternative plan for pay increases for civilian Federal employees covered by the General Schedule and certain other pay systems in January 2010; to the Committee on Homeland Security and Governmental Affairs.

EC–3872. A communication from the Director, Office of Management and Budget, Executive Office of the President, transmitting, pursuant to law, a report relative to unvouchered expenditures; to the Committee on Homeland Security and Governmental Affairs.

EC–3873. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a report on D.C. Act 18–233, ''Neighborhood Supermarket Tax Relief Clarification Temporary Act of 2009''; to the Committee on Homeland Security and Governmental Affairs.

EC–3874. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a report on D.C. Act 18–232, ''First Congregational United Church of Christ Property Tax Abatement Temporary Act of 2009''; to the Committee on Homeland Security and Governmental Affairs.

EC–3875. A communication from the Chairman of the Council of the District of Columbia, transmitting, pursuant to law, a report on D.C. Act 18–231, ''Police and Firefighter Post-Retirement Health Benefits Temporary Amendment Act of 2009''; to the Committee on Homeland Security and Governmental Affairs.

EC–3876. A communication from the Acting Director, U.S. Trade and Development Agency, transmitting, pursuant to law, the Agency's Performance and Accountability Report for fiscal year 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3877. A communication from the Chairman, Securities and Exchange Commission, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report for the period of April 1, 2009, through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3878. A communication from the Chairman, National Endowment for the Arts, transmitting, pursuant to law, the Office of Inspector General's Semiannual Report as well as the Chairman's Report on Final Action for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3879. A communication from the Administrator, National Aeronautics and Space Administration, transmitting, pursuant to law, the Administration's Performance and Accountability Report for fiscal year 2009; to the Committee on Homeland Security and Governmental Affairs.

EC–3880. A communication from the Chairman, Board of Governors, U.S. Postal Service, transmitting, pursuant to law, the Semiannual Report on the Audit, Investigative, and Security Activities of the U.S. Postal Service for the period of April 1, 2009 through September 30, 2009; to the Committee on Homeland Security and Governmental Affairs.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. LIEBERMAN, from the Committee on Homeland Security and Governmental Affairs, with an amendment in the nature of a substitute:

S. 372. A bill to amend chapter 23 of title 5, United States Code, to clarify the disclosures of information protected from prohibited personnel practices, require a statement in nondisclosure policies, forms, and agreements that such policies, forms, and agreements conform with certain disclosure protections, provide certain authority for the Special Counsel, and for other purposes (Rept. No. 111–101).

By Mr. LEAHY, from the Committee on the Judiciary, with an amendment in the nature of a substitute:

S. 1353. A bill to amend title 1 of the Omnibus Crime Control and Safe Streets Act of 1986 to include nonprofit and volunteer ground and air ambulance crew members and first responders for certain benefits.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mr. ROCKEFELLEER for the Committee on Commerce, Science, and Transportation.

Suresh Kumar, of New Jersey, to be Assistant Secretary of Commerce and Director General of the United States and Foreign Commercial Service.

*Scott Boyer Quehl. of Pennsylvania, to be Chief Financial Officer, Department of Commerce.

*Scott Boyer Quehl, of Pennsylvania, to be an Assistant Secretary of Commerce.

*Philip E. Coyle, III, of California, to be an Associate Director of the Office of Science and Technology Policy.

*Anthony R. Coscia, of New Jersey, to be a Director of the Amtrak Board of Directors for a term of five years.

*Albert DiClemente, of Delaware, to be a Director of the Amtrak Board of Directors for the remainder of the term expiring July 26, 2011.

*Mark R. Rosekind, of California, to be a Member of the National Transportation Safety Board for the remainder of the term expiring December 31, 2009.

*Mark R. Rosekind, of California, to be a Member of the National Transportation Safety Board for a term expiring December 31, 2014.

By Mr. LEAHY for the Committee on the Judiciary.

Thomas I. Vanaskie, of Pennsylvania, to be United States Circuit Judge for the Third Circuit.

Louis B. Butler, Jr., of Wisconsin, to be United States District Judge for the Western District of Wisconsin.

Susan B. Carbon, of New Hampshire, to be Director of the Violence Against Women Office, Department of Justice.

John H. Laub, of the District of Columbia, to be Director of the National Institute of Justice.

Sharon Jeanette Lubinski, of Minnesota, to be United States Marshal for the District of Minnesota for the term of four years.

Mary Elizabeth Phillips, of Missouri, to be United States Attorney for the Western District of Missouri for the term of four years.

Sanford C. Coats, of Oklahoma, to be United States Attorney for the Western District of Oklahoma for the term of for years.

Stephen James Smith, of Georgia, to be United States Marshal for the Southern District of Georgia for the term of four years.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

(Nominations without an asterisk were reported with the recommendation that they be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Ms. KLOBUCHAR (for herself, Mr. FEINGOLD, Mr. WEBB, and Mr. BEGICH):

S. 2825. A bill to require cell phone early termination fees to be pro-rated over the term of a subscriber's contract, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. GRASSLEY:

S. 2826. A bill to amend the Internal Revenue Code of 1986 to extend the renewable production credit for wind and open-loop biomass facilities, and for other purposes; to the Committee on Finance.

By Mr. SCHUMER:

S. 2827. A bill to amend the Internal Revenue Code of 1986 to expand the military housing allowance exclusion for purposes of determining area gross income in determining whether a residential rental property for purposes of the exempt facility bond rules; to the Committee on Finance.

By Mr. KERRY:

S. 2828. A bill to amend the Public Health Service Act to authorize the National Institute of Environmental Health Sciences to conduct a research program on endocrine disruption, to prevent and reduce the production of, and exposure to, chemicals that can undermine the development of children before they are born and cause lifelong impairment to their health and function, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. WYDEN (for himself, Ms. STABENOW, and Mrs. GILLIBRAND):

S. 2829. A bill to amend the Internal Revenue Code of 1986 to allow the cost of labor for building envelope improvements to be included for purposes of the nonbusiness energy property tax credit; to the Committee on Finance.

By Mr. BINGAMAN (for himself, Mr. HATCH, Mr. BENNETT, Mr. UDALL of New Mexico, Mr. UDALL of Colorado, and Mr. BENNET):

S. 2830. A bill to amend the Surface Mining Control and Reclamation Act of 1977 to clarify that uncertified States and Indian tribes have the authority to use certain payments for certain noncoal reclamation projects; to the Committee on Energy and Natural Resources.

By Mr. REED (for himself, Mr. SCHUMER, Mrs. SHAHEEN, Mr. LEAHY, Mr. KERRY, Mr. DODD, Mr. WHITEHOUSE, and Mr. CASEY):

S. 2831. A bill to provide for additional emergency unemployment compensation and to keep Americans working, and for other purposes; to the Committee on Finance.

By Mr. BINGAMAN (for himself, Mr. ISAKSON, and Mr. KOHL):

S. 2832. A bill to amend the Employee Retirement Income Security Act of 1974 to require a lifetime income disclosure; to the Committee on Health, Education, Labor, and Pensions.

By Mr. REED (for himself, Mr. BROWN, Mr. WHITEHOUSE, Mr. AKAKA, Mr. DURBIN, Ms. KLOBUCHAR, and Mr. BEGICH):

S. 2833. A bill to provide adjusted Federal medical assistance percentage rates during a transitional assistance period; to the Committee on Finance.

By Mr. AKAKA (for himself and Mr. VOINOVICH):

S. 2834. A bill to amend the Intelligence Reform and Terrorism Prevention Act of 2004 to establish a Security Clearance and Suitability Performance Accountability Council and for other purposes; to the Select Committee on Intelligence.

By Mr. KERRY (for himself, Mr. CARDIN, Mr. KAUFMAN, Mrs. GILLIBRAND, and Mr. MENENDEZ):

S. 2835. A bill to reduce global warming pollution through international climate finance, investment, and for other purposes; to the Committee on Foreign Relations.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. CRAPO (for himself and Ms. KLOBUCHAR):

S. Res. 367. A resolution recognizing the 25th anniversary of the enactment of the Victims of Crime Act of 1984 (42 U.S.C. 10601 et seq.) and the substantial contributions to the Crime Victims Fund made through the criminal prosecutions conducted by the Financial Litigation Units of the United States Attorneys' offices; to the Committee on the Judiciary.

By Mr. NELSON of Florida (for himself and Mr. LEMIEUX):

S. Res. 368. A resolution expressing the sense of the Senate commending coach Bobby Bowden; to the Committee on the Judiciary.

By Mr. MCCONNELL (for himself and Mr. REID):

S. Res. 369. A resolution to permit the collection of clothing, toys, food, and housewares during the holiday season for charitable purposes in Senate buildings; considered and agreed to.

ADDITIONAL COSPONSORS

S. 132

At the request of Mrs. FEINSTEIN, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 132, a bill to increase and enhance law enforcement resources committed to investigation and prosecution of violent gangs, to deter and punish violent gang crime, to protect law-abiding citizens and communities from violent criminals, to revise and enhance criminal penalties for violent crimes, to expand and improve gang prevention programs, and for other purposes.

S. 760

At the request of Mr. BROWNBACK, his name was added as a cosponsor of S. 760, a bill to designate the Liberty Memorial at the National World War I Museum in Kansas City, Missouri, as the ''National World War I Memorial''.

S. 761

At the request of Mr. BROWNBACK, his name was added as a cosponsor of S. 761, a bill to establish the World War I Centennial Commission to ensure a suitable observance of the centennial of World War I, and for other purposes.

S. 827

At the request of Mr. ROCKEFELLER, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 827, a bill to establish a program to reunite bondholders with matured unredeemed United States savings bonds.

S. 1067

At the request of Mr. FEINGOLD, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 1067, a bill to support stabilization and lasting peace in northern Uganda and areas affected by the Lord's Resistance Army through development of a regional strategy to support multilateral efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1147

At the request of Mr. KOHL, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 1147, a bill to prevent tobacco smuggling, to ensure the collection of all tobacco taxes, and for other purposes.

S. 1306

At the request of Mr. BUNNING, the name of the Senator from Tennessee (Mr. CORKER) was added as a cosponsor of S. 1306, a bill to provide for payment to the survivor or surviving family members of compensation otherwise payable to a contractor employee of the Department of Energy who dies after application for compensation under the Energy Employees Occupational Illness Compensation Program Act of 2000, and for other purposes.

S. 1341

At the request of Mr. MENENDEZ, the name of the Senator from Missouri (Mrs. MCCASKILL) was added as a cosponsor of S. 1341, a bill to amend the Internal Revenue Code of 1986 to impose an excise tax on certain proceeds received on SILO and LILO transactions.

S. 1423

At the request of Mrs. BOXER, the name of the Senator from Hawaii (Mr. INOUYE) was added as a cosponsor of S. 1423, a bill to amend title XIX of the Social Security Act to require coverage under the Medicaid Program for freestanding birth center services.

S. 1492

At the request of Ms. MIKULSKI, the name of the Senator from Delaware (Mr. CARPER) was added as a cosponsor of S. 1492, a bill to amend the Public Health Service Act to fund breakthroughs in Alzheimer's disease research while providing more help to caregivers and increasing public education about prevention.

S. 1583

At the request of Mr. ROCKEFELLER, the name of the Senator from Oklahoma (Mr. INHOFE) was added as a cosponsor of S. 1583, a bill to amend the Internal Revenue Code of 1986 to extend the new markets tax credit through 2014, and for other purposes.

S. 1646

At the request of Mr. REED, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. 1646, a bill to keep Americans working by strengthening and expanding short-time compensation programs that provide employers with an alternative to layoffs.

S. 1780

At the request of Mrs. LINCOLN, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 1780, a bill to amend title 38, United States Code, to deem certain service in the reserve components as active service for purposes of laws administered by the Secretary of Veterans Affairs.

S. 1809

At the request of Mr. WICKER, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 1809, a bill to amend the Clean Air Act to promote the certification of aftermarket conversion systems and thereby encourage the increased use of alternative fueled vehicles.

S. 1859

At the request of Mr. ROCKEFELLER, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. 1859, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 2730

At the request of Mr. BROWN, the names of the Senator from Oregon (Mr. MERKLEY) and the Senator from New York (Mr. SCHUMER) were added as cosponsors of S. 2730, a bill to extend and enhance the COBRA subsidy program under the American Recovery and Reinvestment Act of 2009.

S. 2758

At the request of Ms. STABENOW, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of S. 2758, a bill to amend the Agricultural Research, Extension, and Education Reform Act of 1998 to establish a national food safety training, education, extension, outreach, and technical assistance program for agricultural producers, and for other purposes.

S. 2794

At the request of Mr. SCHUMER, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 2794, a bill to amend the Internal Revenue Code of 1986 to provide tax incentives for the donation of wild game meat.

S. 2820

At the request of Mr. LAUTENBERG, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 2820, a bill to prevent the destruction of terrorist and criminal national instant criminal background check system records.

S. RES. 337

At the request of Mr. ENSIGN, his name was added as a cosponsor of S. Res. 337, a resolution designating December 6, 2009, as ''National Miners Day''.

S. RES. 356

At the request of Mr. DURBIN, his name was added as a cosponsor of S. Res. 356, a resolution calling upon the Government of Turkey to facilitate the reopening of the Ecumenical Patriarchate's Theological School of Halki without condition or further delay.

AMENDMENT NO. 2790

At the request of Mr. CASEY, the name of the Senator from Minnesota (Ms. KLOBUCHAR) was added as a cosponsor of amendment No. 2790 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2791

At the request of Ms. MIKULSKI, the names of the Senator from New Hampshire (Mrs. SHAHEEN), the Senator from Montana (Mr. TESTER) and the Senator from New York (Mrs. GILLIBRAND) were added as cosponsors of amendment No. 2791 proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2836

At the request of Ms. MURKOWSKI, the name of the Senator from Georgia (Mr. ISAKSON) was added as a cosponsor of amendment No. 2836 proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. GRASSLEY:

S. 2826. A bill to amend the Internal Revenue Code of 1986 to extend the renewable production credit for wind and open-loop biomass facilities, and for other purposes; to the Committee on Finance.

Mr. GRASSLEY. Mr. President, today I am introducing the Clean Renewable Energy Advancement Tax Extension Jobs Act of 2009, or the CREATE Jobs Act of 2009 for short. This is a bill to help all kinds of businesses create jobs and continue pushing ahead on the development of clean renewable energy. My bill extends the tax credit for the production of electricity from wind and open-loop biomass through December 31, 2016.

It increases the amount of bond authority for new clean renewable energy bonds to incentivize more clean renewable energy projects and the jobs created by these projects. For all businesses, my bill extends bonus depreciation for 1 year, so that businesses are able to deduct half of the value of any property placed in service in 2010.

This tax cut for businesses that invest in new property in 2010 will spur investment in clean energy projects, as well as other new projects, and that will create badly needed jobs.

I urge my colleagues to help me in getting this important legislation enacted into law as soon as possible.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2826

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Clean Renewable Energy Advancement Tax Extension Jobs Act of 2009'' or the ''CREATE Jobs Act''.

SEC. 2. EXTENSION OF RENEWABLE PRODUCTION CREDIT FOR WIND AND OPEN-LOOP BIOMASS FACILITIES.

(a) WIND.—Section 45(d)(1) of the Internal Revenue Code of 1986 is amended by striking ''before January 1, 2013'' and inserting ''before January 1, 2017''.

(b) OPEN-LOOP BIOMASS.—Section 45(d)(3) of the Internal Revenue Code of 1986 is amended by striking ''before January 1, 2014'' both places it appears and inserting ''before January 1, 2017''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to property placed in service after the date of the enactment of this Act.

SEC. 3. INCREASED LIMITATION ON ISSUANCE OF NEW CLEAN RENEWABLE ENERGY BONDS.

(a) ADDITIONAL LIMITATION.—Section 54C(c) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(5) FURTHER INCREASE IN LIMITATION.—The national new clean renewable energy bond limitation shall be increased by $2,200,000,000. Such increase shall be allocated by the Secretary consistent with the rules of paragraphs (2) and (3).''.

(b) NONAPPLICATION OF CERTAIN LABOR STANDARDS TO FURTHER INCREASE IN LIMITATION.—Section 1601(1) of the American Recovery and Reinvestment Tax Act of 2009 is amended by inserting ''pursuant to section 54C(c)(4) of such Code'' after ''Act,''.

(c) NONAPPLICATION OF CERTAIN ARBITRAGE AND ISSUANCE RULES.—Section 54C of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(e) SPECIAL RULES.—For purposes of this section—

''(1) LIMITED ARBITRAGE.—Section 54A(d)(4) shall apply without regard to subparagraph (B) or (C) thereof.

''(2) NO CREDIT STRIPPING.—Section 54A(i) shall not apply.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to bonds issued after the date of the enactment of this Act.

SEC. 4. ADDITIONAL FIRST-YEAR DEPRECIATION FOR 50 PERCENT OF THE BASIS OF CERTAIN QUALIFIED PROPERTY.

(a) IN GENERAL.—Paragraph (2) of section 168(k) of the Internal Revenue Code of 1986, as amended by the American Recovery and Reinvestment Tax Act of 2009, is amended—

(1) by striking ''January 1, 2011'' and inserting ''January 1, 2012'', and

(2) by striking ''January 1, 2010'' each place it appears and inserting ''January 1, 2011''.

(b) CONFORMING AMENDMENTS.—

(1) The heading for subsection (k) of section 168 of the Internal Revenue Code of 1986, as amended by the American Recovery and Reinvestment Tax Act of 2009, is amended by striking ''JANUARY 1, 2010'' and inserting ''JANUARY 1, 2011''.

(2) The heading for clause (ii) of section 168(k)(2)(B) of such Code, as so amended, is amended by striking ''PRE-JANUARY 1, 2010'' and inserting ''PRE-JANUARY 1, 2011''.

(3) Subparagraph (B) of section 168(l)(5) of such Code, as so amended, is amended by striking ''January 1, 2010'' and inserting ''January 1, 2011''.

(4) Subparagraph (C) of section 168(n)(2)of such Code, as so amended, is amended by striking ''January 1, 2010'' and inserting ''January 1, 2011''.

(5) Subparagraph (D) of section 1400L(b)(2) of such Code is amended by striking ''January 1, 2010'' and inserting ''January 1, 2011''.

(6) Subparagraph (B) of section 1400N(d)(3)of such Code, as so amended, is amended by striking ''January 1, 2010'' and inserting ''January 1, 2011''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to property placed in service after December 31, 2009.

By Mr. KERRY:

S. 2828. A bill to amend the Public Health Service Act to authorize the National Institute of Environmental Health Sciences to conduct a research program on endocrine disruption, to prevent and reduce the production of, and exposure to, chemicals that can undermine the development of children before they are born and cause lifelong impairment to their health and function, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. KERRY. Mr. President, there are approximately 80,000 known chemicals in our environment that are potentially harmful. Many of those chemicals are not tested to determine if they are damaging to our health. This includes products Americans use every day such as household cleaners, cosmetics or personal care products.

The increased rate of disorders affecting the human endocrine system is alarming. Children developing in the womb may be particularly vulnerable. We can see the effects in our environment. Some fish in our lakes and rivers are developing gender mutations. We know there may be connections between these effects and the chemicals around us and it is time to learn more about it. That is why I am proud to introduce the Endocrine Disruption Prevention Act.

The Endocrine Disruption Prevention Act simply authorizes the National Institute of Environmental Health Sciences to conduct a research program on chemicals that may pose a risk to our health. This will streamline research efforts so more useful and complete data will be available to Federal agencies with the responsibility of regulating chemicals. This bill allows agencies to fake action based on findings and to report to Congress with what actions were taken.

This bill promotes action based on hard, scientific evidence. I urge my colleagues to support this bill.

By Mr. WYDEN (for himself, Ms. STABENOW, and Mrs. GILLIBRAND):

S. 2829. A bill to amend the Internal Revenue Code of 1986 to allow the cost of labor for building envelope improvements to be included for purposes of the nonbusiness energy property tax credit; to the Committee on Finance.

Mr. WYDEN. Mr. President, the Federal tax code is in great need of an overhaul and today I am introducing legislation to fix one small piece of it. My legislation will help struggling homeowners who are seeing their money literally going out the window as their heating costs go through the roof.

The current tax code gives homeowners a tax credit for installing energy efficiency improvements, which is all well and good, but it only allows labor costs to be included for improvements inside their homes. If the homeowner is installing a new energy efficient furnace, labor costs are included in the expenses eligible for the tax credit. But for improvements like installing energy efficient windows, or doors, or insulation, or energy efficient roofing materials—improvements where labor is a major part of the cost, the tax credit only covers the cost of the materials and not the labor to install them. If this seems counterintuitive and counterproductive, that's because it is. Tilting the tax code to favor some types of home improvements over others is not a sound foundation for tax policy or energy policy.

This legislation, which Senators STABENOW and GILLIBRAND have joined with me to coponsor, will fix this problem by including labor costs for all eligible energy efficiency improvements whether to the heating system or to the roof Our legislation doesn't change the amount of the overall credit or the kinds of energy efficiency improvements that can be made. It just makes it clear that the credit applies equally to labor costs to install all of the qualifying residential energy efficiency improvements, not just some. This will create a level playing field for homeowners when they are trying to decide which improvements to make especially for more labor intensive projects like installing insulation or new energy efficient roofing. It will also make all of these building energy saving opportunities more affordable. Most importantly, it will help Americans actually save energy and it will create jobs for those workers manufacturing and installing new, energy efficiency products.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2829

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. MODIFICATION TO NONBUSINESS ENERGY PROPERTY CREDIT.

(a) IN GENERAL.—Paragraph (1) of section 25C(c) of the Internal Revenue Code of 1986 is amended by adding at the end the following flush sentence:

'' ''Such term includes expenditures for labor costs properly allocable to the onsite preparation, assembly, or original installation of the component.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to property placed in service after the date of the enactment of this Act.

By Mr. BINGAMAN (for himself, Mr. HATCH, Mr. BENNETT, Mr. UDALL of New Mexico, Mr. UDALL of Colorado, and Mr. BENNET):

S. 2830. A bill to amend the Surface Mining Control and Reclamation Act of 1977 to clarify that uncertified States and Indian tribes have the authority to use certain payments for certain noncoal reclamation projects; to the Committee on Energy and Natural Resources.

Mr. BINGAMAN. Mr. President, I rise to introduce a bill important to public health and safety and the environment in the West. This legislation addresses an interpretation by the Department of the Interior, DOI, which restricts the ability of States to use certain funds under the Abandoned Mine Land, AML, Program authorized by the Surface Mining Control and Reclamation Act, SMCRA, for non-coal mine reclamation.

The Tax Relief and Health Care Act of 2006 contained amendments to SMCRA reauthorizing collection of an AML fee on coal produced in the U.S. and making certain modifications to the AML program. Under this program, which is administered by DOI, funds are expended to reclaim abandoned mine lands, with top priority for protecting public health, safety, general welfare, and property, and restoration of land and water resources adversely affected by past mining practices. The program is largely directed to abandoned coal mine reclamation, but under section 409 of SMCRA, funds have been available to address non-coal mine sites.

Pursuant to a Memorandum Opinion, M–37014, issued by the DOI's Solicitor on December 5, 2007, the Department has interpreted the amendments in a manner that limits the ability of western States to use certain funds under SMCRA to address significant problems relating to non-coal abandoned mines. This is in spite of the fact that these funds had previously been available for these purposes. In accordance with section 409 of SMCRA, western States such as New Mexico, Colorado, and Utah, have prioritized the use of AML funds to undertake the most pressing reclamation work on both coal and non-coal mine sites. While activities on non-coal sites have consumed a relatively insignificant portion of the funding provided for the overall AML program, the results in terms of public health and safety in these States is considerable, and there is significant work yet to be done. For example, New Mexico alone has over 15,000 remaining mine openings with a vast majority of these being non-coal. Uranium mine reclamation is a particular priority in New Mexico. All AML-related fatalities in New Mexico in the last few decades have been at non-coal mine sites.

The bill that I am introducing today would correct what I believe is an unfortunate interpretation of the 2006 Amendments by modifying the language of SMCRA to clarify that the funding would be available for non-coal reclamation as it was prior to the passage of the amendments in 2006. Under the bill, which makes a conforming change to sections 409 and 411 of SMCRA, western, non-certified States

could continue to use their State share balances, including amounts comprising their so-called previously unappropriated State share balances, for non-coal reclamation.

I hope that my colleagues will support this legislation, which has important implications for abandoned mine clean-up in the West.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2830

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. ABANDONED MINE RECLAMATION.

(a) LIMITATION ON FUNDS.—Section 409(b) of the Surface Mining Control and Reclamation Act of 1977 (30 U.S.C. 1239(b)) is amended by inserting ''or section 411(h)(1)'' after ''section 402(g)''.

(b) USE OF FUNDS.—Section 411(h)(1)(D)(ii) of the Surface Mining Control and Reclamation Act of 1977 (30 U.S.C. 1240a(h)(1)(D)(ii)) is amended by inserting ''or 409'' after ''section 403''.

By Mr. REED (for himself, Mr. SCHUMER, Mrs. SHAHEEN, Mr. LEAHY, Mr. KERRY, Mr. DODD, Mr. WHITEHOUSE, and Mr. CASEY):

S. 2831. A bill to provide for additional emergency unemployment compensation and to keep Americans working, and for other purposes; to the Committee on Finance.

Mr. REED. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2831

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Helping Unemployed Workers Act''.

SEC. 2. EXTENSION OF EMERGENCY UNEMPLOYMENT COMPENSATION PROGRAM.

(a) IN GENERAL.—Section 4007 of the Supplemental Appropriations Act, 2008 (Public Law 110–252; 26 U.S.C. 3304 note), as amended by section 4 of the Unemployment Compensation Extension Act of 2008 (Public Law 110–449; 122 Stat. 5015) and section 2001(a) of the Assistance for Unemployed Workers and Struggling Families Act (Public Law 111–5; 123 Stat. 436), is amended—

(1) by striking ''December 31, 2009'' each place it appears and inserting ''December 31, 2010'';

(2) in the heading for subsection (b)(2), by striking ''DECEMBER 31, 2009'' and inserting ''DECEMBER 31, 2010''; and

(3) in subsection (b)(3), by striking ''May 31, 2010'' and inserting ''May 31, 2011''.

(b) FUNDING.—Section 4004(e)(1) of the Supplemental Appropriations Act, 2008 (Public Law 110–252; 26 U.S.C. 3304 note), as amended by section 6 of the Worker, Homeownership, and Business Assistance Act of 2009 (Public Law 111–92), is amended by striking ''by reason of'' and all that follows and inserting the following: ''by reason of—

''(A) the amendments made by section 2001(a) of the Assistance for Unemployed Workers and Struggling Families Act;

''(B) the amendments made by sections 2 through 4 of the Worker, Homeownership, and Business Assistance Act of 2009; and

''(C) the amendments made by section 2(a) of the Helping Unemployed Workers Act; and''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect as if included in the enactment of the Supplemental Appropriations Act, 2008.

SEC. 3. EXTENSION OF INCREASE IN UNEMPLOYMENT COMPENSATION BENEFITS.

(a) IN GENERAL.—Section 2002(e) of the Assistance for Unemployed Workers and Struggling Families Act (Public Law 111–5; 123 Stat. 438) is amended—

(1) in paragraph (1)(B), by striking ''January 1, 2010'' and inserting ''January 1, 2011'';

(2) in the heading for paragraph (2), by striking ''JANUARY 1, 2010'' and inserting ''JANUARY 1, 2011''; and

(3) in paragraph (3), by striking ''June 30, 2010'' and inserting ''June 30, 2011''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of the Assistance for Unemployed Workers and Struggling Families Act.

SEC. 4. EXTENSION OF FULL FEDERAL FUNDING OF EXTENDED UNEMPLOYMENT COMPENSATION FOR A LIMITED PERIOD.

(a) IN GENERAL.—Section 2005 of the Assistance for Unemployed Workers and Struggling Families Act (Public Law 111–5; 26 U.S.C. 3304 note) is amended—

(1) by striking ''January 1, 2010'' each place it appears and inserting ''January 1, 2011''; and

(2) in subsection (c), by striking ''June 1, 2010'' and inserting ''June 1, 2011''.

(b) EXTENSION OF TEMPORARY FEDERAL MATCHING FOR THE FIRST WEEK OF EXTENDED BENEFITS FOR STATES WITH NO WAITING WEEK.—Section 5 of the Unemployment Compensation Extension Act of 2008 (Public Law 110–449; 26 U.S.C. 3304 note), as amended by section 2005(d) of the Assistance for Unemployed Workers and Struggling Families Act (Public Law 111–5; 26 U.S.C. 3304 note), is amended by striking ''May 30, 2010'' and inserting ''May 30, 2011''.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsection (a) shall take effect as if included in the enactment of the Assistance for Unemployed Workers and Struggling Families Act.

(2) FIRST WEEK.—The amendment made by subsection (b) shall take effect as if included in the enactment of the Unemployment Compensation Extension Act of 2008.

SEC. 5. MODIFICATION TO ELIGIBILITY REQUIREMENTS FOR EMERGENCY UNEMPLOYMENT COMPENSATION.

(a) INDIVIDUAL NOT INELIGIBLE BY REASON OF SUBSEQUENT ENTITLEMENT TO REGULAR BENEFITS.—Section 4001 of the Supplemental Appropriations Act, 2008 (Public Law 110–252; 26 U.S.C. 3304 note) is amended by adding at the end the following new subsection:

''(g) CERTAIN RIGHTS TO REGULAR COMPENSATION DISREGARDED.—If an individual exhausted the individual's rights to regular compensation for any benefit year, such individual's eligibility to receive emergency unemployment compensation under this title in respect of such benefit year shall be determined without regard to any rights to regular compensation for a subsequent benefit year if such individual does not file a claim for regular compensation for such subsequent benefit year.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall apply to weeks of unemployment beginning after the date of the enactment of this Act.

(2) TRANSITION RULES.—

(A) WAIVER OF RECOVERY OF CERTAIN OVERPAYMENTS.—On and after the date of the enactment of this Act, no repayment of any emergency unemployment compensation shall be required under section 4005 of the Supplemental Appropriations Act, 2008 (Public Law 110–252; 26 U.S.C. 3304 note) if the individual would have been entitled to receive such compensation had the amendment made by subsection (a) applied to all weeks beginning on or before the date of the enactment of this Act.

(B) WAIVER OF RIGHTS TO CERTAIN REGULAR BENEFITS.—If—

(i) before the date of the enactment of this Act, an individual exhausted the individual's rights to regular compensation for any benefit year, and

(ii) after such exhaustion, such individual was not eligible to receive emergency unemployment compensation under title IV of the Supplemental Appropriations Act, 2008 (Public Law 110–252; 26 U.S.C. 3304 note) by reason of being entitled to regular compensation for a subsequent benefit year,

such individual may elect to defer the individual's rights to regular compensation for such subsequent benefit year with respect to weeks beginning after such date of enactment until such individual has exhausted the individual's rights to emergency unemployment compensation in respect of the benefit year referred to in clause (i), and such individual shall be entitled to receive emergency unemployment compensation for such weeks in the same manner as if the individual had not been entitled to the regular compensation to which the election applies.

SEC. 6. SUSPENSION OF TAX ON PORTION OF UNEMPLOYMENT COMPENSATION.

(a) IN GENERAL.—Section 85(c) of the Internal Revenue Code of 1986 is amended—

(1) by inserting ''or 2010'' after ''in 2009'', and

(2) by inserting ''AND 2010'' in the heading after ''2009''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 7. TREATMENT OF SHORT-TIME COMPENSATION PROGRAMS.

(a) IN GENERAL.—Section 3306 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(v) SHORT-TIME COMPENSATION PROGRAM.—For purposes of this chapter, the term 'short-time compensation program' means a program under which—

''(1) the participation of an employer is voluntary;

''(2) an employer reduces the number of hours worked by employees through certifying that such reductions are in lieu of temporary layoffs;

''(3) such employees whose workweeks have been reduced by at least 10 percent are eligible for unemployment compensation;

''(4) the amount of unemployment compensation payable to any such employee is a pro rata portion of the unemployment compensation which would be payable to the employee if such employee were totally unemployed;

''(5) such employees are not expected to meet the availability for work or work search test requirements while collecting short-time compensation benefits, but are required to be available for their normal workweek;

''(6) eligible employees may participate in an employer-sponsored training program to enhance job skills if such program has been approved by the State agency;

''(7) beginning on the date which is 2 years after the date of enactment of this subsection, the employer certifies that continuation of health benefits and retirement benefits under a defined benefit pension plan (as defined in section 3(35) of the Employee Retirement Income Security Act of 1974) is not affected by participation in the program;

''(8) the employer (or an employer's association which is party to a collective bargaining agreement) submits a written plan describing the manner in which the requirements of this subsection will be implemented and containing such other information as the Secretary of Labor determines is appropriate;

''(9) in the case of employees represented by a union, the appropriate official of the union has agreed to the terms of the employer's written plan and implementation is consistent with employer obligations under the National Labor Relations Act; and

''(10) the program meets such other requirements as the Secretary of Labor determines appropriate.''.

(b) ASSISTANCE AND GUIDANCE IN IMPLEMENTING PROGRAMS.—

(1) ASSISTANCE AND GUIDANCE.—

(A) IN GENERAL.—In order to assist States in establishing, qualifying, and implementing short-time compensation programs, as defined in section 3306(v) of the Internal Revenue Code of 1986 (as added by subsection (a)), the Secretary of Labor (in this section referred to as the ''Secretary'') shall—

(i) develop model legislative language which may be used by States in developing and enacting short-time compensation programs and shall periodically review and revise such model legislative language;

(ii) provide technical assistance and guidance in developing, enacting, and implementing such programs;

(iii) establish biannual reporting requirements for States, including number of averted layoffs, number of participating companies and workers, and retention of employees following participation; and

(iv) award start-up grants to State agencies under subparagraph (B).

(B) GRANTS.—

(i) IN GENERAL.—The Secretary shall award start-up grants to State agencies that apply not later than June 30, 2011, in States that enact short-time compensation programs after the date of enactment of this Act for the purpose of creating such programs. The amount of such grants shall be awarded depending on the costs of implementing such programs.

(ii) ELIGIBILITY.—In order to receive a grant under clause (i) a State agency shall meet requirements established by the Secretary, including any reporting requirements under clause (iii). Each State agency shall be eligible to receive not more than one such grant.

(iii) REPORTING.—The Secretary may establish reporting requirements for State agencies receiving a grant under clause (i) in order to provide oversight of grant funds used by States for the creation of short-time compensation programs.

(iv) FUNDING.—There are appropriated, out of any moneys in the Treasury not otherwise appropriated, to the Secretary, such sums as the Secretary certifies as necessary for the period of fiscal years 2010 and 2011 to carry out this subparagraph.

(2) TIMEFRAME.—The initial model legislative language referred to in paragraph (1)(A) shall be developed not later than 60 days after the date of enactment of this Act.

(c) REPORTS.—

(1) INITIAL REPORT.—Not later than 4 years after the date of enactment of this Act, the Secretary shall submit to Congress and to the President a report or reports on the implementation of this section. Such report or reports shall include—

(A) a study of short-time compensation programs;

(B) an analysis of the significant impediments to State enactment and implementation of such programs; and

(C) such recommendations as the Secretary determines appropriate.

(2) SUBSEQUENT REPORTS.—After the submission of the report under paragraph (1), the Secretary may submit such additional reports on the implementation of short-time compensation programs as the Secretary deems appropriate.

(3) FUNDING.—There are appropriated, out of any moneys in the Treasury not otherwise appropriated, to the Secretary, $1,500,000 to carry out this subsection, to remain available without fiscal year limitation.

(d) CONFORMING AMENDMENTS.—

(1) INTERNAL REVENUE CODE OF 1986.—

(A) Subparagraph (E) of section 3304(a)(4) of the Internal Revenue Code of 1986 is amended to read as follows:

''(E) amounts may be withdrawn for the payment of short-time compensation under a short-time compensation program (as defined in section 3306(v));''.

(B) Subsection (f) of section 3306 of the Internal Revenue Code of 1986 is amended—

(i) by striking paragraph (5) (relating to short-term compensation) and inserting the following new paragraph:

''(5) amounts may be withdrawn for the payment of short-time compensation under a short-time compensation program (as defined in subsection (v));'', and

(ii) by redesignating paragraph (5) (relating to self-employment assistance program) as paragraph (6).

(2) SOCIAL SECURITY ACT.—Section 303(a)(5) of the Social Security Act is amended by striking ''the payment of short-time compensation under a plan approved by the Secretary of Labor'' and inserting ''the payment of short-time compensation under a short-time compensation program (as defined in section 3306(v) of the Internal Revenue Code of 1986)''.

(3) REPEAL.—Subsections (b) through (d) of section 401 of the Unemployment Compensation Amendments of 1992 (26 U.S.C. 3304 note) are repealed.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

SEC. 8. TEMPORARY FINANCING OF CERTAIN SHORT-TIME COMPENSATION PROGRAMS.

(a) PAYMENTS TO STATES WITH CERTIFIED PROGRAMS.—

(1) IN GENERAL.—Not later than 30 days after the date of enactment of this Act, the Secretary shall establish a program under which the Secretary shall make payments to any State unemployment trust fund to be used for the payment of unemployment compensation if the Secretary approves an application for certification submitted under paragraph (3) for such State to operate a short-time compensation program (as defined in section 3306(v) of the Internal Revenue Code of 1986 (as added by section 7(a))) which requires the maintenance of health and retirement employee benefits as described in paragraph (7) of such section 3306(v), in addition to other requirements of this Act and notwithstanding the otherwise effective date of such requirement.

(2) REIMBURSEMENT.—Subject to subsection (d), the payment to a State under paragraph (1) shall be an amount equal to 100 percent of the total amount of benefits paid to individuals by the State pursuant to the short-time compensation program during the weeks of unemployment—

(A) beginning on or after the date the certification is issued by the Secretary with respect to such program; and

(B) ending on or before December 31, 2011.

(3) CERTIFICATION REQUIREMENTS.—

(A) IN GENERAL.—Any State seeking full reimbursement under this subsection shall submit an application for certification at such time, in such manner, and complete with such information as the Secretary may require (whether by regulation or otherwise), including information relating to compliance with the requirements of paragraph (7) of such section 3306(v). The Secretary shall, within 30 days after receiving a complete application, notify the State agency of the State of the Secretary's findings with respect to the requirements of such paragraph (7).

(B) FINDINGS.—If the Secretary finds that the short-time compensation program operated by the State meets the requirements of such paragraph (7), the Secretary shall certify such State's short-time compensation program thereby making such State eligible for reimbursement under this subsection.

(b) TIMING OF APPLICATION SUBMITTALS.—No application under subsection (a)(3) may be considered if submitted before the date of enactment of this Act or after the latest date necessary (as specified by the Secretary) to ensure that all payments under this section are made before December 31, 2011.

(c) TERMS OF PAYMENTS.—Payments made to a State under subsection (a)(1) shall be payable by way of reimbursement in such amounts as the Secretary estimates the State will be entitled to receive under this section for each calendar month, reduced or increased, as the case may be, by any amount by which the Secretary finds that the Secretary's estimates for any prior calendar month were greater or less than the amounts which should have been paid to the State. Such estimates may be made on the basis of such statistical, sampling, or other method as may be agreed upon by the Secretary and the State agency of the State involved.

(d) LIMITATIONS.—

(1) GENERAL PAYMENT LIMITATIONS.—No payments shall be made to a State under this section for benefits paid to an individual by the State in excess of 26 weeks of benefits.

(2) EMPLOYER LIMITATIONS.—No payments shall be made to a State under this section for benefits paid to an individual by the State pursuant to a short-time compensation program if such individual is employed by an employer—

(A) whose workforce during the 3 months preceding the date of the submission of the employer's short-time compensation plan has been reduced by temporary layoffs of more than 20 percent; or

(B) on a seasonal, temporary, or intermittent basis.

(3) PROGRAM PAYMENT LIMITATION.—In making any payments to a State under this section pursuant to a short-time compensation program, the Secretary may limit the frequency of employer participation in such program.

(e) RETENTION REQUIREMENT.—

(1) IN GENERAL.—A participating employer under this section is required to comply with the terms of the written plan approved by the State agency and act in good faith to retain participating employees.

(2) OVERSIGHT AND MONITORING.—The Secretary shall establish an oversight and monitoring process by which State agencies will ensure that participating employers comply with the requirements of paragraph (1).

(f) FUNDING.—There are appropriated, from time to time, out of any moneys in the Treasury not otherwise appropriated, to the

Secretary, such sums as the Secretary certifies are necessary to carry out this section (including to reimburse any additional administrative expenses by reason of the provision of, and amendments made by, this Act that are incurred by the States in operating such short-time compensation programs).

(g) DEFINITION OF STATE.—In this section, the term ''State'' includes the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands.

(h) SUNSET.—The provisions of this section shall not apply after December 31, 2011.

SEC. 9. STUDY AND REPORTS ON THE EMERGENCY UNEMPLOYMENT COMPENSATION PROGRAM.

(a) STUDY.—The Secretary of Labor (in this section referred to as the ''Secretary'') shall conduct a study on the implementation of the emergency unemployment compensation program under title IV of the Supplemental Appropriations Act, 2008 (Public Law 110–252; 26 U.S.C. 3304 note), as amended by section 2 and the Worker, Homeownership, and Business Assistance Act of 2009 (Public Law 111–92). Such study shall include an analysis of—

(1) the different tiers under such program;

(2) the number of initial claims under such program, the average duration of benefits under the program, the average sum of benefits under the program, and other areas that demonstrate who received benefits under the program;

(3) any significant impediments to State implementation of such program;

(4) the significant administration weaknesses and strengths of such programs; and

(5) other areas determined appropriate by the Secretary.

(b) REPORTS.—

(1) IN GENERAL.—Not later than 4 years after the date of the enactment of this Act, the Secretary shall submit to Congress and the President a report (or multiple reports) on the study conducted under subsection (a), together with such recommendations as the Secretary determines appropriate.

(2) SUBSEQUENT REPORTS.—After the Secretary submits the report (or reports) required under paragraph (1), the Secretary may submit such additional reports on the implementation of emergency unemployment compensation programs as the Secretary deems appropriate.

(c) FUNDING.—There are appropriated, out of any moneys in the Treasury not otherwise appropriated, to the Secretary, $1,250,000 to carry out this section, to remain available without fiscal year limitation.

By Mr. BINGAMAN (for himself, Mr. ISAKSON, and Mr. KOHL):

S. 2832. A bill to amend the Employee Retirement Income Security Act of 1974 to require a lifetime income disclosure; to the Committee on Health, Education, Labor, and Pensions.

Mr. BINGAMAN. Mr. President, I rise today to introduce the Lifetime Income Disclosure Act, to help Americans ensure they do not outlive their retirement savings. I am pleased to be joined by my colleague on the Health, Education, Labor and Pensions Committee, Senator ISAKSON, and the Chairman of the Aging Committee, Senator KOHL, in introducing the Act. In sum, the Act would require private defined contribution retirement plans annually to show plan participants how their account balances translate into monthly income equivalents, based on age at retirement and other factors. The act is structured so as not to impose a material burden on employers.

As life expectancies rise, individuals have an increasing need for protection against the risk that they will outlive their savings. In fact, Boston College's National Retirement Risk Index recently found that half of American households are ''at risk'' of being unable to maintain their pre-retirement standard of living in retirement.

But trends in retirement plan coverage are only increasing this risk. Defined benefit pension plans—to which employers make regular fixed contributions—are becoming rare. Individuals who receive any form of workplace retirement account are increasingly offered the opportunity to contribute to defined contribution plans, like 401(k)s, to which the employer may or may not provide a matching contribution. At present, 401(k) plan statements typically provide a total account balance, but not a monthly income equivalent. Consequently, employees are not well-prepared to evaluate whether they are saving adequately to maintain cost of their current standard of living in retirement.

To address this challenge, the act would require that defined contribution plans subject to ERISA, such as 401(k) plans, include ''annuity equivalents'' on benefit statements provided to employees. An annuity equivalent is the monthly annuity payment that would be made if the employee's total account balance were used to buy a life annuity that commenced payments at the plan's normal retirement age, generally 65. The act requires the statement to show the monthly annuity payments under both a single life annuity and a qualified joint and survivor annuity—that is, an annuity with survivor benefits payable for life to the employee's spouse. The annuity equivalents would only be required to be provided once a year, even where quarterly statements are otherwise required.

In this regard, 401(k) benefit statements would become better coordinated with Social Security benefit statements, which only express benefits in the form of a life annuity. Knowing the amount of monthly income they can expect from Social Security and their define contribution plan will help employees determine whether they are on the path to a secure retirement. Additionally, including annuity equivalents on benefit statements will make employees more aware of the possibility upon retirement of receiving at least a portion of their benefit in the form of an annuity that protects them against outliving their savings.

As I have already discussed, this proposal addresses a critical public policy issue. But it is equally important that the proposal be structured not to impose any material burden or potential liability on employers that voluntarily maintain a plan. Thus, the act directs the Department of Labor to issue, within a year, assumptions that employers may use in converting a lump sum amount into an annuity equivalent. Accordingly, employers will be able to base their annuity equivalents entirely on clear mechanical assumptions prescribed by the DOL. Of course, to the extent that a participant's benefit is or may be invested in an annuity contract that guarantees a specified annuity benefit, the DOL shall, to the extent appropriate, permit such specified benefit to be treated as an annuity equivalent.

The DOL would further be directed to issue, within a year, a model disclosure that explains the assumptions used to determine the annuity equivalents and the fact that the annuity equivalents provided are only estimates. This model disclosure would include a clear explanation that actual annuity benefits may be materially different from such estimates.

The act also provides employers with a clear path to avoid liability: under the act, employers and service providers using the model disclosure and following the prescribed assumptions and DOL rules would not have any liability with regard to the provision of annuity equivalents. This exemption from liability would apply to any disclosure of an annuity equivalent that incorporates the explanation from the model disclosure and that is prepared in accordance with the prescribed assumptions and DOL rules. For example, subject to such conditions, the exemption would apply to annuity equivalents available on a Web site or provided quarterly.

Finally, the act would not go into effect until a year after the DOL has issued the guidance needed by employers to implement the new rules.

Our proposal is a small step, but one that can make a significant difference in beginning to tackle a key policy challenge. I am pleased that the act enjoys the support of many advocates for retirement security, including AARP, the Women's Institute for a Secure Retirement, and the Council of Independent 401(k) Recordkeepers. I look forward to working with Senators ISAKSON and KOHL to see these provisions enacted into law.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2832

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Lifetime Income Disclosure Act''.

SEC. 2. DISCLOSURE REGARDING LIFETIME INCOME.

(a) IN GENERAL.—Subparagraph (B) of section 105(a)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1025(a)(2)) is amended—

(1) in clause (i), by striking ''and'' at the end;

(2) in clause (ii), by striking ''diversification.'' and inserting ''diversification, and''; and

(3) by inserting at the end the following:

''(iii) the lifetime income disclosure described in subparagraph (D)(i).

In the case of pension benefit statements described in clause (i) of paragraph (1)(A), a lifetime income disclosure under clause (iii) of this subparagraph shall only be required to be included in one pension benefit statement in each calendar year.''.

(b) LIFETIME INCOME.—Paragraph (2) of section 105(a) of such Act (29 U.S.C. 1025(a)) is amended by adding at the end the following new subparagraph:

''(D) LIFETIME INCOME DISCLOSURE.—

''(i) IN GENERAL.—

''(I) DISCLOSURE.—A lifetime income disclosure shall set forth the annuity equivalent of the total benefits accrued with respect to the participant or beneficiary.

''(II) ANNUITY EQUIVALENT OF THE TOTAL BENEFITS ACCRUED.—For purposes of this subparagraph, the 'annuity equivalent of the total benefits accrued' means the amount of monthly payments the participant or beneficiary would receive at the plan's normal retirement age if the total accrued benefits of such participant or beneficiary were used on the date of the lifetime income disclosure to purchase the life annuities described in subclause (III), with payments under such annuities commencing at the plan's normal retirement age.

''(III) LIFE ANNUITIES.—The life annuities described in this subclause are a qualified joint and survivor annuity (as defined in section 205(d)), based on assumptions specified in rules prescribed by the Secretary, including the assumption that the participant or beneficiary has a spouse of equal age, and a single life annuity. Such annuities may have a term certain or other features to the extent permitted under rules prescribed by the Secretary.

''(ii) MODEL DISCLOSURE.—Not later than 1 year after the date of the enactment of the Lifetime Income Disclosure Act, the Secretary shall issue a model lifetime income disclosure, written in a manner so as to be understood by the average plan participant, that—

''(I) explains that the annuity equivalent is only provided as an illustration;

''(II) explains that the actual annuity payments that may be purchased with the total benefits accrued will depend on numerous factors and may vary substantially from the annuity equivalent in the disclosures;

''(III) explains the assumptions upon which the annuity equivalent was determined; and

''(IV) provides such other similar explanations as the Secretary considers appropriate.

''(iii) ASSUMPTIONS AND RULES.—Not later than 1 year after the date of the enactment of the Lifetime Income Disclosure Act, the Secretary shall—

''(I) prescribe assumptions that administrators of individual account plans may use in converting total accrued benefits into annuity equivalents for purposes of this subparagraph; and

''(II) issue interim final rules under clause (i).

In prescribing assumptions under subclause (I), the Secretary may prescribe a single set of specific assumptions (in which case the Secretary may issue tables or factors that facilitate such conversions), or ranges of permissible assumptions. To the extent that an accrued benefit is or may be invested in an annuity contract, the assumptions prescribed under subclause (I) shall, to the extent appropriate, permit administrators of individual account plans to use the amounts payable under such contract as an annuity equivalent.

''(iv) LIMITATION ON LIABILITY.—No plan fiduciary, plan sponsor, or other person shall have any liability under this title solely by reason of the provision of annuity equivalents which are derived in accordance with the assumptions and rules described in clause (iii) and which include the explanations contained in the model lifetime income disclosure described in clause (ii). This clause shall apply without regard to whether the provision of such annuity equivalent is required by subparagraph (B)(iii).

''(v) EFFECTIVE DATE.—The requirement in subparagraph (B)(iii) shall apply to pension benefit statements furnished more than 12 months after the latest of the issuance by the Secretary of—

''(I) interim final rules under clause (i);

''(II) the model disclosure under clause (ii); or

''(III) the assumptions under clause (iii).''.

By Mr. REED (for himself, Mr. BROWN, Mr. WHITEHOUSE, Mr. AKAKA, Mr. DURBIN, Ms. KLOBUCHAR, and Mr. BEGICH):

S. 2833. A bill to provide adjusted Federal medical assistance percentage rates during a transitional assistance period; to the Committee on Finance.

Mr. REED. Mr. President, I rise today to introduce the Transitional Federal Medical Assistance Percentage, FMAP, Act, and I am pleased to do so with the support of Senators BROWN, WHITEHOUSE, AKAKA, DURBIN, KLOBUCHAR, and BEGICH. This bill is an important step in continuing the conversation about how we can help our States, businesses, and individuals as our economy recovers.

In my State of Rhode Island, the economic downturn has been particularly hard hitting on families and businesses. As a result, the State has seen a decline in tax revenue and an increased enrollment in safety net programs like Medicaid. Revenue from the sales tax is down over 7 percent, income tax receipts are down 2.3 percent, and corporate tax revenue is down nearly 10 percent. At the same time, unemployment rates have soared to new heights, topping 13 percent earlier this year. In the past 2 years, 40,000 Rhode Islanders have lost their employer-sponsored health insurance. Many of these individuals have come to rely on Medicaid for health coverage. This has caused great strain on the State's resources and its Medicaid program. In November, we learned that the estimated Medicaid caseload for the year will cost over $40 million more than what the State had initially estimated in its budget.

The American Recovery and Reinvestment Act, which I supported, provided States with additional Federal assistance through 2010. States have used these funds to help balance their budgets, minimize harmful cuts in public services, and, very importantly, to prevent tax increases in many cases. However, even with the funding from the Recovery Act, Rhode Island will close the current fiscal year $219.8 million in the red.

A total of 38 States have looked ahead to fiscal year 2011, and they have estimated $92 billion in combined deficits in the coming year. As the State fiscal year nears, and more States have had ample time to analyze their fiscal health it is expected that the total shortfall will likely equal $180 billion.

As Congress debates health reform and works to ensure that every American has access to health insurance in 2014, we must not forget about ensuring that Americans have access to health insurance between now and then, as the economy slowly recovers and as state budgets begin to heal. During this tough time we need to help individuals, businesses, and States, and I am particularly concerned with making sure our States have the resources to provide adequate health care.

Unless Congress acts on FMAP legislation, States will be forced to use their limited resources to cover an expanded Medicaid population beginning in January 2011. Since States are planning their fiscal year 2011 budgets, which will begin in July, many Governors are requesting Congress act now to provide States with additional Federal support.

The Transitional FMAP Act would extend the enhanced FMAP funding which we passed in the Recovery Act for two additional quarters. This extension accounts for the prolonged recession and ensures that the pressure of Medicaid needs do not overwhelm the States. The bill would also begin a slow decrease of enhanced FMAP funding from July 2011 through December 2013. This will help States as they recover and ensure that States do not experience a gap in assistance prior to health reform-related FMAP levels beginning in January 2014.

Mr. President, this additional funding is important for States, businesses, and individuals. I know that Chairman BAUCUS and Leader REID are well aware of the importance of FMAP and have a history to working to aid our States. I look forward to working with them and my other colleagues to provide States with necessary additional Federal Medicaid assistance.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2833

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Transitional Federal Medical Assistance Percentage Act''.

SEC. 2. EXTENSION OF ARRA INCREASE IN FMAP.

Section 5001 of ARRA is amended—

(1) in subsection (a)(3), by striking ''first calendar quarter'' and inserting ''first 3 calendar quarters'';

(2) in subsection (b)(2), by inserting before the period at the end the following: ''and such paragraph shall not apply to calendar quarters beginning on or after October 1, 2010'';

(3) in subsection (d), by inserting ''ending before October 1, 2010'' after ''entire fiscal years'' and after ''with respect to fiscal years'';

(4) in subsection (g)(1), by striking ''September 30, 2011'' and inserting ''December 31, 2011''; and

(5) in subsection (h)(3), by striking ''December 31, 2010'' and inserting ''June 30, 2011''.

SEC. 3. ARRA TRANSITIONAL ASSISTANCE PERIOD.

For each fiscal quarter occurring during the period beginning on July 1, 2011, and ending on December 31, 2013 (referred to in this Act as the ''ARRA transitional assistance period''), a State's FMAP shall be equal to the sum of—

(1) the adjusted base FMAP (as determined under section 4(a)(1));

(2) the general FMAP adjustment (as determined under section 4(a)(2)); and

(3) the unemployment FMAP adjustment (as determined under section 4(a)(3)).

SEC. 4. ADJUSTMENTS TO FEDERAL MEDICAL ASSISTANCE PERCENTAGE.

(a) DETERMINATION OF ADJUSTED FMAP.—

(1) ADJUSTED BASE FMAP.—

(A) IN GENERAL.—Subject to subparagraph (B), the adjusted base FMAP is determined as follows:

(i) For the fourth quarter of fiscal year 2011, the FMAP that would have applied to the State under section 5001(a) of ARRA (assuming that such section applied) for such fiscal quarter minus 2 percentage points.

(ii) For any subsequent fiscal quarter occurring during the ARRA transitional assistance period, the FMAP as determined under this paragraph for the preceding fiscal quarter minus 2 percentage points.

(B) ELIMINATION OF NEGATIVE ADJUSTMENT.—If the adjusted base FMAP applicable to a State under this paragraph for any fiscal quarter occurring during the ARRA transitional assistance period would be less than the FMAP determined for the State for such quarter without regard to this paragraph, this paragraph shall not apply to such State.

(2) GENERAL FMAP ADJUSTMENT.—The general FMAP adjustment shall be equal to the following:

(A) For the fourth quarter of fiscal year 2011, 5.7 percentage points.

(B) For the first quarter of fiscal year 2012, 4.95 percentage points.

(C) For the second quarter of fiscal year 2012, 3.95 percentage points.

(D) For the third quarter of fiscal year 2012, 2.7 percentage points.

(E) For the fourth quarter of fiscal year 2012, 1.2 percentage points.

(F) For any subsequent fiscal quarter occurring during the ARRA transitional assistance period, 0.2 percentage points.

(3) UNEMPLOYMENT FMAP ADJUSTMENT.—

(A) IN GENERAL.—Subject to subparagraphs (C) and (D), the unemployment FMAP adjustment shall be equal to the increase in the State's FMAP that would have applied to the State under section 5001(c) of ARRA (assuming that such section applied) for such fiscal quarter minus the applicable reduction amount (as described under subparagraph (B)).

(B) APPLICABLE REDUCTION AMOUNT.—For purposes of subparagraph (A), the applicable reduction amount shall be equal to the following:

(i) For the fourth fiscal quarter of fiscal year 2011, 0.20 percentage points.

(ii) For any subsequent fiscal quarter occurring during the ARRA transitional assistance period, the sum of—

(I) the applicable reduction amount for the preceding fiscal quarter; and

(II) 0.05 percentage points.

(C) ELIMINATION OF NEGATIVE ADJUSTMENT.—If the unemployment FMAP adjustment applicable to a State under this paragraph for any fiscal quarter during the ARRA transitional assistance period would be less than zero, this paragraph shall not apply to such State.

(D) SPECIAL RULE.—

(i) IN GENERAL.—For purposes of subparagraph (A), with respect to the computation of the state unemployment increase percentage (as described under section 5001(c)(4) of ARRA) for the last 2 fiscal quarters of the ARRA transitional assistance period, the most recent previous 3-consecutive-month period (as described under section 5001(c)(4)(A)(i) of ARRA) shall be the 3-consecutive-month period beginning with December 2012, or, if it results in a higher applicable percent under section 5001(c)(3) of ARRA, the 3-consecutive-month period beginning with January 2013.

(ii) REPEAL OF SPECIAL RULE UNDER ARRA FOR LAST 2 CALENDAR QUARTERS OF THE RECESSION ADJUSTMENT PERIOD.—Section 5001(c)(4) of ARRA is amended by striking subparagraph (C) and inserting the following:

''(C) SPECIAL RULE.—With respect to the first 2 calendar quarters of the recession adjustment period, the most recent previous 3-consecutive-month period described in subparagraph (A)(i) shall be the 3-consecutive-month period beginning with October 2008.''.

(b) SCOPE OF APPLICATION.—The adjustments in the FMAP for a State under this section shall apply for purposes of title XIX of the Social Security Act and shall not apply with respect to—

(1) disproportionate share hospital payments described in section 1923 of such Act (42 U.S.C. 1396r-4);

(2) payments under title IV of such Act (42 U.S.C. 601 et seq.) (except that the increases under paragraphs (1) and (2) of subsection (a) shall apply to payments under part E of title IV of such Act (42 U.S.C. 670 et seq.) and, for purposes of the application of this section to the District of Columbia, payments under such part shall be deemed to be made on the basis of the FMAP applied with respect to such District for purposes of title XIX and as increased under subsection (a)(2));

(3) any payments under title XXI of such Act (42 U.S.C. 1397aa et seq.);

(4) any payments under title XIX of such Act that are based on the enhanced FMAP described in section 2105(b) of such Act (42 U.S.C. 1397ee(b)); or

(5) any payments under title XIX of such Act that are attributable to expenditures for medical assistance provided to individuals made eligible under a State plan under title XIX of the Social Security Act (including under any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) because of income standards (expressed as a percentage of the poverty line) for eligibility for medical assistance that are higher than the income standards (as so expressed) for such eligibility as in effect on July 1, 2008, (including as such standards were proposed to be in effect under a State law enacted but not effective as of such date or a State plan amendment or waiver request under title XIX of such Act that was pending approval on such date).

(c) STATE INELIGIBILITY; LIMITATION; SPECIAL RULES.—

(1) MAINTENANCE OF ELIGIBILITY REQUIREMENTS.—

(A) IN GENERAL.—Subject to subparagraph (B) and (C), a State is not eligible for an increase in its FMAP under subsection (a) if eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008.

(B) STATE REINSTATEMENT OF ELIGIBILITY PERMITTED.—Subject to subparagraph (C), a State that has restricted eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) after July 1, 2008, is no longer ineligible under subparagraph (A) beginning with the first calendar quarter in which the State has reinstated eligibility standards, methodologies, or procedures that are no more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008.

(C) SPECIAL RULES.—A State shall not be ineligible under subparagraph (A)—

(i) for the fiscal quarters before October 1, 2011, on the basis of a restriction that was applied after July 1, 2008, and before the date of the enactment of this Act, if the State prior to October 1, 2011, has reinstated eligibility standards, methodologies, or procedures that are no more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008; or

(ii) on the basis of a restriction that was directed to be made under State law as in effect on July 1, 2008, and would have been in effect as of such date, but for a delay in the effective date of a waiver under section 1115 of such Act with respect to such restriction.

(2) COMPLIANCE WITH PROMPT PAY REQUIREMENTS.—

(A) APPLICATION TO PRACTITIONERS.—

(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, no State shall be eligible for an increased FMAP rate as provided under this section for any claim received by a State from a practitioner subject to the terms of section 1902(a)(37)(A) of the Social Security Act (42 U.S.C. 1396a(a)(37)(A)) for such days during any period in which that State has failed to pay claims in accordance with such section as applied under title XIX of such Act.

(ii) REPORTING REQUIREMENT.—Each State shall report to the Secretary, on a quarterly basis, its compliance with the requirements of clause (i) as such requirements pertain to claims made for covered services during each month of the preceding quarter.

(iii) WAIVER AUTHORITY.—The Secretary may waive the application of clause (i) to a State, or the reporting requirement imposed under clause (ii), during any period in which there are exigent circumstances, including natural disasters, that prevent the timely processing of claims or the submission of such a report.

(iv) APPLICATION TO CLAIMS.—Clauses (i) and (ii) shall only apply to claims made for covered services after the date of enactment of this Act.

(B) APPLICATION TO NURSING FACILITIES AND HOSPITALS.—The provisions of subparagraph (A) shall apply with respect to a nursing facility or hospital, insofar as it is paid under title XIX of the Social Security Act on the basis of submission of claims, in the same or similar manner (but within the same timeframe) as such provisions apply to practitioners described in such subparagraph.

(3) STATE'S APPLICATION TOWARD RAINY DAY FUND.—A State is not eligible for an increase in its FMAP under paragraphs (2) or (3) of subsection (a) if any amounts attributable (directly or indirectly) to such increase are deposited or credited into any reserve or rainy day fund of the State.

(4) NO WAIVER AUTHORITY.—Except as provided in paragraph (2)(A)(iii), the Secretary may not waive the application of this subsection or subsection (d) under section 1115 of the Social Security Act or otherwise.

(5) LIMITATION OF FMAP TO 100 PERCENT.—In no case shall an increase in FMAP under this section result in an FMAP that exceeds 100 percent.

(d) REQUIREMENTS.—

(1) STATE REPORTS.—Each State that is paid additional Federal funds as a result of this section shall, not later than September 30, 2014, submit a report to the Secretary, in such form and such manner as the Secretary shall determine, regarding how the additional Federal funds were expended.

(2) ADDITIONAL REQUIREMENT FOR CERTAIN STATES.—In the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures under the State Medicaid plan required under section 1902(a)(2) of the Social Security Act (42 U.S.C. 1396a(a)(2)), the State is not eligible for an increase in its FMAP under paragraphs (2) or (3) of subsection (a) if it requires that such political subdivisions pay for quarters during the ARRA transitional assistance period a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923, than the respective percentage that would have been required by the State under such plan on September 30, 2008, prior to application of this section.

(e) DEFINITIONS.—In this Act, except as otherwise provided:

(1) ARRA.—The term ''ARRA'' means the American Recovery and Reinvestment Act of 2009 (Public Law 111–5; 123 Stat. 140).

(2) FMAP.—The term ''FMAP'' means the Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as determined without regard to this section except as otherwise specified.

(3) POVERTY LINE.—The term ''poverty line'' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(5) STATE.—The term ''State'' has the meaning given such term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(f) SUNSET.—This section shall not apply to items and services furnished after the end of the ARRA transitional assistance period.

By Mr. AKAKA (for himself and Mr. VOINOVICH):

S. 2834. A bill to amend the Intelligence Reform and Terrorism Prevention Act of 2004 to establish a Security Clearance and Suitability Performance Accountability Council and for other purposes; to the Select Committee on Intelligence.

Mr. AKAKA. Mr. President, today I am introducing, along with my colleague Senator VOINOVICH, the Security Clearance Modernization and Reporting Act of 2009.

Since 2005, our Homeland Security and Governmental Affairs Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia has held a series of six oversight hearings on the serious shortfalls of the Federal Government's ability to effectively and efficiently issue security clearances to federal employees and contractors.

This issue was placed on the Government Accountability Office's, GAO, High-Risk List in 2005. Since then, through the strong oversight of our Subcommittee and hard work of those in the government dedicated to reforming and modernizing the security clearance process, the tremendous backlog of security clearance investigations has all but vanished, and clearance determinations are made much more quickly. While progress has been made, we must use this opportunity to continue to push for fundamental changes to the clearance process to ensure that we do not experience the same problems in the future.

In 2004, the Intelligence Reform and Terrorism Prevention Act, IRTPA, P.L. 108–458, required 90 percent of clearances to be completed within an average of 60 days by December 2009. At the time, it took almost a year to complete a Top Secret clearance request. IRTPA also required that agencies recognize clearance determinations made by other agencies to ensure reciprocity of clearances. An Executive Order was issued to implement these requirements, designating the Office of Management and Budget, OMB, as the agency responsible for setting security clearance policy and calling on the Office of Personnel Management, OPM, to conduct clearance investigations. Unfortunately, clearance timeliness continued to be unacceptably slow.

After continued pressure from our Subcommittee and other stakeholders, in 2008, OMB brought together the Department of Defense, the Office of the Director of National Intelligence, ODNI, and OPM to create a plan to overhaul and streamline the clearance process government-wide. At the recommendation of this reform team, a new executive order was issued creating a governance structure for overseeing and modernizing the federal government's security clearance and suitability processes. The members of the reform team were designated as the Suitability and Security Clearance Performance Accountability Council, PAC.

Since the creation of the PAC and the implementation of some reforms, including enhanced application processes, new clearance standards, and plans for electronic adjudication and reevaluation, timeliness of clearances has greatly improved. Already, agencies are generally meeting goals laid out by the IRTPA. However, this has required tremendous effort and a surge in investigation capacity over several years to address backlogs.

The bill that we are introducing today would address the lingering concerns over the clearance process and help sustain the momentum for reforming and modernizing the security clearance and suitability determination processes.

First, to ensure accountability in security clearance reform and modernization, it is necessary to produce more detailed timeliness reporting. Today, OMB only reports the average timeliness of the 90 fastest percent of clearances. At our Subcommittee hearings, the GAO has repeatedly called for expanded reporting. It is important that we look at the timeliness of the whole process. Our legislation would require more complete reporting on timeliness for all clearances, not just the 90 percent that we see today. For the first time, it would require OMB to break down the numbers based on types of clearances and employee groups, and to report on which agencies are complying with reciprocal recognition of clearances. While the current IRTPA reporting requirements end in 2011, our legislation would extend these requirements to ensure that we receive reports until GAO has concluded this is no longer a high-risk issue.

To ensure consistent leadership, our bill would codify the Performance Accountability Council, which has been the catalyst for much of the reform we have seen to date. It is critical that we codify the PAC as its future was in doubt during the presidential transition as the new administration reviewed previous executive orders.

GAO has also urged the creation of new metrics that would measure not only the timeliness of clearance determinations, but also the quality and completeness of investigations. These metrics should be defined through the creation of a comprehensive strategic plan for clearance modernization. In response to GAO's recommendations, the legislation would require the PAC to create a comprehensive strategic plan. This plan would outline reform goals, establish performance measures, create a more robust communications strategy, define clear roles and responsibilities for stakeholders, and examine funding needs in order to keep reforms on track.

Finally, this bill would require that the PAC undertake a more comprehensive information technology assessment than it has to date. Today, dozens of intertwined systems are used in the clearance process. These systems are a patchwork of outdated technology owned by different agencies. Rather than conducting an inventory of the current technology in use, as the PAC has already done, our bill would require a true needs assessment to define the most effective information technology approach.

Our Subcommittee, under both my leadership and that of Senator Voinovich, has worked in a bipartisan manner on this issue seamlessly for several years and our oversight has yielded positive results. It is vital, from both a human capital perspective and a national security perspective, that security clearances and suitability determinations be of the highest quality and made in a timely manner. We must work to make sure this issue is removed from the High-Risk List as soon as possible.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2834

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Security Clearance Modernization and Reporting Act of 2009''.

SEC. 2. DEFINITIONS.

Subsection (a) of section 3001 of the Intelligence Reform and Terrorism Prevention Act of 2004 (50 U.S.C. 435b) is amended—

(1) in the matter preceding paragraph (1) by striking ''In this section:'' and inserting ''Except as otherwise specifically provided, in this title:'';

(2) by redesignating paragraph (1) as paragraph (2);

(3) by redesignating paragraph (2) as paragraph (5);

(4) by redesignating paragraph (3) as paragraph (4);

(5) by redesignating paragraph (4) as paragraph (12);

(6) by redesignating paragraph (5) as paragraph (10);

(7) by redesignating paragraph (6) as paragraph (15);

(8) by redesignating paragraph (7) as paragraph (14);

(9) by redesignating paragraph (8) as paragraph (3);

(10) by inserting before paragraph (2), as redesignated by paragraph (2), the following:

''(1) ADJUDICATION.—The term 'adjudication' means the evaluation of pertinent data in a background investigation and any other available information that is relevant and reliable to determine whether an individual is—

''(A) suitable for Federal Government employment;

''(B) eligible for logical and physical access to federally controlled information systems;

''(C) eligible for physical access to federally controlled facilities;

''(D) eligible for access to classified information;

''(E) eligible to hold a sensitive position; or

''(F) fit to perform work for or on behalf of the Federal Government as a contractor employee.'';

(11) by inserting after paragraph (5), as redesignated by paragraph (3), the following:

''(6) CLASSIFIED INFORMATION.—The term 'classified information' means information that has been determined, pursuant to Executive Order 12958 (60 Fed. Reg. 19825) or a successor or predecessor order, or the Atomic Energy Act of 1954 (42 U.S.C. 2011 et seq.), to require protection against unauthorized disclosure.

''(7) CONTINUOUS EVALUATION.—The term 'continuous evaluation' means a review of the background of an individual who has been determined to be eligible for access to classified information (including additional or new checks of commercial databases, Government databases, and other information lawfully available to security officials) at any time during the period of eligibility to determine whether that individual continues to meet the requirements for eligibility for access to classified information.

''(8) CONTRACTOR.—The term 'contractor' means an expert or consultant, who is not subject to section 3109 of title 5, United States Code, to an agency, an industrial or commercial contractor, licensee, certificate holder, or grantee of any agency, including all subcontractors, a personal services contractor, or any other category of person who performs work for or on behalf of an agency and who is not an employee of an agency.

''(9) CONTRACTOR EMPLOYEE FITNESS.—The term 'contractor employee fitness' means fitness based on character and conduct for work for or on behalf of an agency as a contractor employee.'';

(12) by inserting after paragraph (10), as redesignated by paragraph (6), the following:

''(11) FEDERALLY CONTROLLED FACILITIES; FEDERALLY CONTROLLED INFORMATION SYSTEMS.—The term 'federally controlled facilities' and 'federally controlled information systems' have the meanings prescribed in guidance pursuant to the Federal Information Security Management Act of 2002 (title III of Public Law 107–347; 116 Stat. 2946), the amendments made by that Act, and Homeland Security Presidential Directive 12, or any successor Directive.'';

(13) by inserting after paragraph (12), as redesignated by paragraph (5), the following:

''(13) LOGICAL ACCESS.—The term 'logical access' means, with respect to federally controlled information systems, access other than occasional or intermittent access to federally controlled information systems.'';

(14) by inserting after paragraph (15), as redesignated by paragraph (7), the following:

''(16) PHYSICAL ACCESS.—The term 'physical access' means, with respect to federally controlled facilities, access other than occasional or intermittent access to federally controlled facilities.

''(17) SENSITIVE POSITION.—The term 'sensitive position' means any position designated as a sensitive position under Executive Order 10450 or any successor Executive Order.

''(18) SUITABILITY.—The term 'suitability' has the meaning of that term in part 731, of title 5, Code of Federal Regulations or any successor similar regulation.''.

SEC. 3. SECURITY CLEARANCE AND SUITABILITY DETERMINATION REPORTING.

(a) EXTENSION OF REPORTING REQUIREMENTS.—Paragraph (1) of section 3001(h) of the Intelligence Reform and Terrorism Prevention Act of 2004 (50 U.S.C. 435b(h)) is amended by striking ''through 2011,'' and inserting ''until the earlier of the date that is 2 years after the date that the Comptroller General of the United States has removed all items related to security clearances from the list maintained by the Comptroller General known as the High-Risk List or 2017,''.

(b) REPORTS ON SECURITY CLEARANCE REVIEW PROCESSES.—Paragraph (2) of such section 3001(h) is amended—

(1) by redesignating subparagraphs (B) and (C) as subparagraphs (E) and (F), respectively; and

(2) by striking subparagraph (A) and inserting the following:

''(A) a description of the full range of time required to complete initial clearance applications, including time required by each authorized investigative agency and each authorized adjudicative agency—

''(i) to respond to requests for security clearances for individuals, including the periods required to initiate security clearance investigations, conduct security clearance investigations, deliver completed investigations to the requesting agency, adjudicate such requests, make final determinations on such requests, and notify individuals and individuals' employers of such determinations, from date of submission of the requests to the date of the ultimate disposition of the requests and notifications, disaggregated by the type of security clearance, including Secret, Top Secret, and Top Secret with Special Program Access, including sensitive compartmented information clearances—

''(I) for civilian employees of the United States;

''(II) for members of the Armed Forces of the United States; and

''(III) for contractor employees; and

''(ii) to conduct investigations for suitability determinations for individuals from successful submission of applications to ultimate disposition of applications and notifications to the individuals—

''(I) for civilian employees of the United States;

''(II) for members of the Armed Forces of the United States; and

''(III) for contractor employees; and

''(B) a listing of the agencies and departments of the United States that have established and utilize policies to accept all security clearance background investigations and determinations completed by an authorized investigative agency or authorized adjudicative agency;

''(C) a description of the progress in implementing the strategic plan referred to in section 3004;

''(D) a description of the progress made in implementing the information technology strategy referred to in section 3005;''.

SEC. 4. SECURITY CLEARANCE AND SUITABILITY PERFORMANCE ACCOUNTABILITY COUNCIL.

Title III of the Intelligence Reform and Terrorism Prevention Act of 2004 (50 U.S.C. 435b et seq.) is amended by adding at the end the following new section:

''SEC. 3003. SECURITY CLEARANCE AND SUITABILITY PERFORMANCE ACCOUNTABILITY COUNCIL.

''(a) ESTABLISHMENT.—There is established a Security Clearance and Suitability Performance Accountability Council (hereinafter referred to as the 'Council').

''(b) CHAIR.—

''(1) DESIGNATION.—The Deputy Director for Management, Office of Management and Budget, shall serve as Chair of the Council.

''(2) AUTHORITY.—The Chair of the Council shall have authority, direction, and control over the functions of the Council.

''(c) VICE CHAIR.—The Chair of the Council shall select a Vice Chair to act in the Chair's absence.

''(d) MEMBERSHIP.—

''(1) IN GENERAL.—The members of the Council shall include—

''(A) the Chair of the Council; and

''(B) an appropriate senior officer from each of the following:

''(i) The Office of the Director of National Intelligence.

''(ii) The Department of Defense.

''(iii) The Office of Personnel Management.

''(2) OTHER MEMBERS.—The Chair of the Council may designate appropriate employees of other agencies or departments of the United States as members of the Council.

''(e) DUTIES.—The Council shall—

''(1) ensure alignment of suitability, security, and, as appropriate, contractor employee fitness, investigative, and adjudicative processes;

''(2) ensure alignment of investigative requirements for suitability determinations and security clearances to reduce duplication in investigations;

''(3) oversee the establishment of requirements for enterprise information technology;

''(4) oversee the development of techniques and tools, including information technology, for enhancing background investigations and eligibility determinations and ensure that such techniques and tools are utilized;

''(5) ensure that each agency and department of the United States establishes and utilizes policies for ensuring reciprocal recognition of clearances that allow access to classified information granted by all other agencies and departments;

''(6) ensure sharing of best practices among agencies and departments of the United States;

''(7) hold each agency and department of the United States accountable for the implementation of suitability, security, and, as appropriate, contractor employee fitness processes and procedures; and

''(8) hold each agency and department of the United States accountable for recognizing clearances that allow access to classified information granted by all other agencies and departments of the United States.

''(f) ASSIGNMENT OF DUTIES.—The Chair may assign, in whole or in part, to the head of any agency or department of the United States, solely or jointly, any duty of the Council relating to—

''(1) alignment and improvement of investigations and determinations of suitability;

''(2) determinations of contractor employee fitness; and

''(3) determinations of eligibility—

''(A) for logical access to federally controlled information systems;

''(B) for physical access to federally controlled facilities;

''(C) for access to classified information; or

''(D) to hold a sensitive position.''.

SEC. 5. STRATEGIC PLAN FOR REFORM.

Title III of the Intelligence Reform and Terrorism Prevention Act of 2004 (50 U.S.C. 435b et seq.), as amended by section 4, is further amended by adding at the end the following new section:

''SEC. 3004. SECURITY CLEARANCE AND SUITABILITY REFORM STRATEGIC PLAN.

''(a) REQUIREMENT FOR PLAN.—Not later than 90 days after the date of the enactment of the Security Clearance Modernization and Reporting Act of 2009, the Security Clearance and Suitability Performance Accountability Council established in section 3003 shall develop a strategic plan that identifies the causes of problems with the issuance of security clearances and a description of actions to be taken to correct such problems.

''(b) CONTENTS.—The plan required by subsection (a) shall include a description of—

''(1) the clear mission and strategic goals of the plan;

''(2) performance measures to be used to determine the effectiveness of security clearance procedures, including measures for the quality of security clearance investigations and adjudications;

''(3) a formal communications strategy related to the issuance of security clearances;

''(4) the roles and responsibilities for agencies participating in security clearance reform efforts; and

''(5) the long-term funding requirements for security clearance reform efforts.

''(c) SUBMISSION TO CONGRESS.—The plan required by subsection (a) shall be submitted to the appropriate committees of Congress.

''(d) GOVERNMENT ACCOUNTABILITY OFFICE REVIEW.—The plan required by subsection (a) shall be reviewed by the Comptroller General of the United States following its submission to the appropriate committees of Congress under subsection (c).''.

SEC. 6. INFORMATION TECHNOLOGY STRATEGY.

Title III of the Intelligence Reform and Terrorism Prevention Act of 2004 (50 U.S.C. 435b et seq.), as amended by sections 4 and 5, is further amended by adding at the end the following new section:

''SEC. 3005. INFORMATION TECHNOLOGY STRATEGY.

''(a) REQUIREMENT FOR STRATEGY.—Not later than 120 days after the date of the enactment of the Security Clearance Modernization and Reporting Act of 2009, the Director of the Office of Management and Budget shall submit to the appropriate committees of Congress an information technology strategy that describes the plans to expedite investigative and adjudicative processes, verify standard information submitted as part of an application for a security clearance, and provide security clearance and suitability determination reform consistent with the strategy required by section 3004(a), by carrying out the Enterprise Information Technology Strategy referred to in the Report of the Joint Security and Suitability Reform Team, dated December 30, 2008.

''(b) CONTENT.—The strategy required by subsection (a) shall include—

''(1) a description of information technology required to request a security clearance or suitability investigation;

''(2) a description of information technology required to apply for a security clearance or suitability investigation;

''(3) a description of information technology systems needed to support such investigations;

''(4) a description of information technology required to transmit common machine readable investigation files to agencies for adjudication;

''(5) a description of information technology required to support agency adjudications of security clearance and suitability determinations;

''(6) a description of information technology required to support continuous evaluations;

''(7) a description of information technology required to implement a single repository containing all security clearance and suitability determinations of each agency and department of the United States that is accessible by each such agency and department in support of ensuring reciprocal recognition of access to classified information among such agencies and departments;

''(8) a description of the efforts of the Security Clearance and Suitability Performance Council established in section 3003, and each of the Department of Defense, the Office of Personnel Management, and the Office of the Director of National Intelligence to carry out the strategy submitted under subsection (a);

''(9) the plans of the agencies and departments of the United States to develop, implement, fund, and provide personnel to carry out the strategy submitted under subsection (a);

''(10) cost estimates to carry out the strategy submitted under subsection (a); and

''(11) a description of the schedule for carrying out the strategy submitted under subsection (a).''.

SEC. 7. TECHNICAL AND CLERICAL AMENDMENTS.

(1) TECHNICAL CORRECTION.—The table of contents in section 1(b) of the Intelligence Reform and Terrorism Prevention Act of 2004 (Public Law 108–458; 118 Stat. 3638) is amended by adding after the item relating to section 3001 the following:

''Sec. 3002. Security clearances; limitations.''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1(b) of the Intelligence Reform and Terrorism Prevention Act of 2004, as amended by paragraph (1), is further amended by adding after the item relating to section 3002, as added by such paragraph, the following:

''Sec. 3003. Security Clearance and Suitability Performance Accountability Council.

''Sec. 3004. Security clearance and suitability reform strategic plan.

''Sec. 3005. Information technology strategy.''.

Mr. VOINOVICH. Mr. President, I rise today to join my good friend and Chairman on the Oversight of Government Management Subcommittee, Senator AKAKA, to ensure that security clearance reform efforts begun in recent years continue by cosponsoring the Security Clearance Modernization and Reporting Act of 2009.

Since the 1990s, the Government's Accountability Office, GAO, has documented problems with the Department of Defense's, DoD, personnel security clearance program, and in 2005 added the program to its high-risk list. DoD's personnel security clearance program has remained on the 2007 and 2009 high risk lists.

In an effort to address this matter and improve the security clearance process, Congress set benchmarks for the time taken to issue clearances in the Intelligence Reform and Terrorism Prevention Act of 2004, IRTPA. IRTPA also required the President to select a single agency or office to oversee the security clearance process across the federal government and required uniform policies regarding the security clearance process, reciprocal recognition of security clearances among agencies, an evaluation of technology to expedite security clearance processes, and a plan to reduce the length of the security clearance process. While progress has been made to decrease the amount of time it takes to obtain a security clearance, more improvement is needed to fully reform the security clearance process, but reform efforts have been delayed this year by an interagency review of the security clearance reform initiatives undertaken over the past several years.

To ensure that the good work begun with passage of IRTPA in 2004, I am pleased to cosponsor Senator AKAKA's legislation that extends IRTPA's reporting requirements relating to security clearance reform efforts beyond their current 2011 expiration date and requires more details in those reports about the amount of time required by individual agencies to conduct both security clearance investigations and adjudications. To ensure that efforts begun over the past several years continue, the bill codifies portions of Executive Order 13467, which deals with reforming processes related to eligibility for access to classified information. The bill also calls for the development of the strategic plan GAO has been asking for since the DoD personnel security clearance program was put on its high risk list in 2005 and requires a more detailed information technology strategy relating to security clearance reform efforts.

I am proud to cosponsor this bill and thank the Senator from Hawaii for his work on this legislation to address such an important issue.

By Mr. KERRY (for himself, Mr. CARDIN, Mr. KAUFMAN, Mrs. GILLIBRAND, and Mr. MENENDEZ):

S. 2835. A bill to reduce global warming pollution through international climate finance, investment, and for other purposes; to the Committee on Foreign Relations.

Mr. KAUFMAN. Mr. President, I am pleased to join the Chairman of the Foreign Relations Committee and my colleagues to introduce an important piece of legislation, the International Climate Change Investment Act of 2009. Climate change is a global issue and only a concerted international response can succeed. This legislation provides key elements of an international deal that will both protect our planet and meet our Nation's international responsibilities. Even more importantly in these times, it will open the door to a green economy that can create jobs here for the markets abroad for clean energy goods and services.

Successful global climate negotiations will create the opportunity for us to transform our own economy, to free ourselves from dependence on fossil fuels from foreign sources, and to create the jobs and markets for a new, sustainable economy.

This legislation establishes a new framework for a global market in clean energy technologies. A complete agenda to confront climate change will include support for our educational base and for the research, development, and deployment of clean technologies. A climate deal that moves us away from fossil fuels will create global demand for those technologies. Building capacity and encouraging dramatic change in other countries will create a pool of customers for America's innovators.

That global market offers us the best chance to create a new economy based on a growing demand for clean energy goods and services—and that will support job creation and profits here at home. Companies in my home state of Delaware and across America are ready and eager to seize this opportunity for a world's worth of new markets. Our smartest investors agree.

This legislation shows the rest of the world that we are ready to do our part to make a smart, effective, and fair international climate change agreement work. It sets us on a firm forward footing to lead the way in tomorrow's green economy.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 367—RECOGNIZING THE 25TH ANNIVERSARY OF THE ENACTMENT OF THE VICTIMS OF CRIME ACT OF 1984 (42 U.S.C. 10601 ET SEQ.) AND THE SUBSTANTIAL CONTRIBUTIONS TO THE CRIME VICTIMS FUND MADE THROUGH THE CRIMINAL PROSECUTIONS CONDUCTED BY THE FINANCIAL LITIGATION UNITS OF THE UNITED STATES ATTORNEYS' OFFICES

Mr. CRAPO (for himself and Ms. KLOBUCHAR) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 367

Whereas the Victims of Crime Act of 1984 has its 25th anniversary this year;

Whereas for 25 years, the Victims of Crime Act of 1984 has provided funds to States for victim assistance and compensation programs to support victims of crime and those affected by violent crimes;

Whereas the Victims of Crime Act of 1984 has enabled approximately 4,400 community-based public and private programs to offer services to victims of crime, including crisis intervention, counseling, guidance, legal advocacy, and transportation shelters;

Whereas the Victims of Crime Act of 1984 provides assistance and monetary support to over 4,000,000 victims of crime each year;

Whereas the Crime Victims Fund established under the Victims of Crime Act of 1984 provides direct services to victims of sexual assault, spousal abuse, child abuse, survivors of homicide victims, elderly victims of abuse or neglect, victims of drunk drivers, and other such crimes;

Whereas in 2008, the Victims of Crime Act of 1984 assisted State crime victim compensation programs by allocating $432,000,000 to 151,643 victims of violent crime;

Whereas since the establishment of the Crime Victims Fund in 1984, nearly $12,000,000,000 in offender-generated, non-taxpayer funds have been deposited into the Crime Victims Fund solely to help victims of crime;

Whereas the Victims of Crime Act of 1984 also supports services to victims of Federal crimes, by providing funds for victims and witness coordinators in United States Attorneys' offices, Federal Bureau of Investigation victim-assistance specialists, and the Federal Victim Notification System; and

Whereas the Victims of Crime Act of 1984 also supports important improvements in the victim services field through grants for training and technical assistance and evidence-based demonstration projects: Now, therefore, be it

Resolved, That the Senate recognizes—

(1) the 25th anniversary of the enactment of the Victims of Crime Act of 1984 (42 U.S.C. 10601 et seq.); and

(2) the substantial contributions to the Crime Victims Fund made through the criminal prosecutions conducted by the Financial Litigation Units of the United States Attorneys' offices.

SENATE RESOLUTION 368—EXPRESSING THE SENSE OF THE SENATE COMMENDING COACH BOBBY BOWDEN

Mr. NELSON of Florida (for himself and Mr. LEMIEUX) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 368

Whereas Bobby Bowden, over a 44-year career during which he coached at Howard College (now Samford University), West Virginia University, and Florida State University, where he has coached for the past 34 years, established a record as one of the most successful coaches in college football history;

Whereas the 388 coaching victories of Bobby Bowden are second only to the 393 coaching victories recorded by Joe Paterno at Pennsylvania State University;

Whereas Bobby Bowden coached Florida State University to 2 national championships in 1993 and 1999, and to a bowl game in every year since 1982, making it the longest streak in the Nation;

Whereas Bobby Bowden helped promote 164 student athletes onto careers in the National Football League;

Whereas Bobby Bowden profoundly influenced many professional and collegiate coaches and players with his wisdom, loyalty, and warmth; and

Whereas the accomplishments of Bobby Bowden on and off the field have come to personify Florida State University: Now, therefore, be it

Resolved, That it is the sense of the Senate that Bobby Bowden is to be commended for his monumental achievements.

SENATE RESOLUTION 369—TO PERMIT THE COLLECTION OF CLOTHING, TOYS, FOOD, AND HOUSEWARES DURING THE HOLIDAY SEASON FOR CHARITABLE PURPOSES IN SENATE BUILDINGS

Mr. MCCONNELL (for himself and Mr. REID) submitted the following resolution; which was considered and agreed to:

S. RES. 369

Resolved,

SECTION 1. COLLECTION OF CLOTHING, TOYS, FOOD, AND HOUSEWARES DURING THE HOLIDAY SEASON FOR CHARITABLE PURPOSES IN SENATE BUILDINGS.

(a) IN GENERAL.—Notwithstanding any other provision of the rules or regulations of the Senate—

(1) a Senator, officer, or employee of the Senate may collect from another Senator, officer, or employee of the Senate within Senate buildings nonmonetary donations of clothing, toys, food, and housewares for charitable purposes related to serving those in need or members of the Armed Services and their families during the holiday season, if such purposes do not otherwise violate any rule or regulation of the Senate or of Federal law; and

(2) a Senator, officer, or employee of the Senate may work with a nonprofit organization with respect to the delivery of donations described in paragraph (1).

(b) EXPIRATION.—The authority provided by this resolution shall expire at the end of the 1st session of the 111th Congress.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2860. Mr. FEINGOLD submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 2861. Mr. FEINGOLD submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2862. Mr. KOHL (for himself, Mr. GRASSLEY, Mr. FEINGOLD, Ms. KLOBUCHAR, Mr. FRANKEN, Mr. NELSON of Florida, and Mr. BROWN) submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2863. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2864. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself,

Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2865. Mr. BURRIS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2866. Mr. SPECTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2867. Mr. SPECTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2868. Mr. BURRIS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2869. Mr. NELSON of Florida (for himself, Mr. ROCKEFELLER, Mr. BEGICH, Mr. LEAHY, Mr. BROWN, Ms. STABENOW, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2870. Mr. WHITEHOUSE proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra.

SA 2871. Mr. BROWN (for himself and Mrs. HUTCHISON) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2872. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2873. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2874. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2875. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2876. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2877. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2878. Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 2879. Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2860. Mr. FEINGOLD submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 797, strike line 11 and all that follows through page 801, line 4, and insert the following:

SEC. 3102A. ELIMINATION OF GEOGRAPHIC PHYSICIAN WORK ADJUSTMENT FACTOR FROM GEOGRAPHIC INDICES USED TO ADJUST PAYMENTS UNDER THE PHYSICIAN FEE SCHEDULE.

(a) FINDINGS.—Congress finds the following:

(1) Variations in the geographic physician work adjustment factors under section 1848(e) of the Social Security Act (42 U.S.C. 1395w–4(e)) result in inequity between localities in payments under the Medicare physician fee schedule.

(2) Beneficiaries under the Medicare program that reside in areas where such adjustment factors are high have relatively more access to services that are paid based on such fee schedule.

(3) There are a number of studies indicating that the market for health care professionals has become nationalized and historically low labor costs in rural and small urban areas have disappeared.

(4) Elimination of the adjustment factors described in paragraph (1) would equalize the reimbursement rate for services reimbursed under the Medicare physician fee schedule while remaining budget-neutral.

(b) ELIMINATION.—Section 1848(e) of the Social Security Act (42 U.S.C. 1395w–4(e)) is amended—

(1) in paragraph (1)(A)(iii), by striking ''an index'' and inserting ''for services provided before January 1, 2010, an index''; and

(2) in paragraph (2), by inserting '', for services provided before January 1, 2010,'' after ''paragraph (4)), and''.

(c) BUDGET NEUTRALITY ADJUSTMENT FOR ELIMINATION OF GEOGRAPHIC PHYSICIAN WORK ADJUSTMENT FACTOR.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended—

(1) in paragraph (1)(A), by striking ''The conversion'' and inserting ''Subject to paragraph (10), the conversion''; and

(2) by adding at the end the following new paragraph:

''(10) BUDGET NEUTRALITY ADJUSTMENT FOR ELIMINATION OF GEOGRAPHIC PHYSICIAN WORK ADJUSTMENT FACTOR.—Before applying an update for a year under this subsection, the Secretary shall (if necessary) provide for an adjustment to the conversion factor for that year to ensure that the aggregate payments under this part in that year shall be equal to aggregate payments that would have been made under such part in that year if the amendments made by section 3102A(b) of the Patient Protection and Affordable Care Act had not been enacted.''.

SEC. 3102B. CLINICAL ROTATION DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—Not later than 6 months after the date of enactment of this Act, the Secretary shall establish a demonstration project that provides for demonstration grants designed to provide financial or other incentives to hospitals to attract educators and clinical practitioners so that hospitals that serve beneficiaries under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) who are residents of underserved areas may host clinical rotations.

(b) DURATION OF PROJECT.—The demonstration project shall be conducted over a 5-year period.

(c) WAIVER.—The Secretary shall waive such provisions of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq. and 1395 et seq.) as may be necessary to conduct the demonstration project under this section.

(d) REPORTS.—The Secretary shall submit to the appropriate committees of Congress interim reports on the demonstration project and a final report on such project within 6 months after the conclusion of the project, together with recommendations for such legislation or administrative action as the Secretary determines to be appropriate.

(e) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section, $20,000,000.

(f) DEFINITIONS.—In this section:

(1) HOSPITAL.—The term ''hospital'' means a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) that had indirect or direct costs of medical education during the most recent cost reporting period preceding the date of enactment of this Act.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(3) UNDERSERVED AREA.—The term ''underserved area'' means such medically underserved urban areas and medically underserved rural areas as the Secretary may specify.

SEC. 3102C. MEDICARE RURAL HEALTH CARE QUALITY IMPROVEMENT DEMONSTRATION PROJECTS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish not more that 10 demonstration projects to provide for improvements, as recommended by the Institute of Medicine, in the quality of health care provided to individuals residing in rural areas.

(2) ACTIVITIES.—Activities under the projects may include public health surveillance, emergency room videoconferencing, virtual libraries, telemedicine, electronic health records, data exchange networks, and any other activities determined appropriate by the Secretary.

(3) CONSULTATION.—The Secretary shall consult with the Office of Rural Health Policy of the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services in carrying out the provisions of this section.

(b) DURATION.—Each demonstration project under this section shall be conducted over a 4-year period.

(c) DEMONSTRATION PROJECT SITES.—The Secretary shall ensure that the demonstration projects under this section are conducted at a variety of sites representing the diversity of rural communities in the United States.

(d) WAIVER.—The Secretary shall waive such provisions of titles XI and XVIII of the

Social Security Act (42 U.S.C. 1301 et seq. and 1395 et seq.) as may be necessary to conduct the demonstration projects under this section.

(e) INDEPENDENT EVALUATION.—The Secretary shall enter into an arrangement with an entity that has experience working directly with rural health systems for the conduct of an independent evaluation of the demonstration projects conducted under this section.

(f) REPORTS.—The Secretary shall submit to the appropriate committees of Congress interim reports on each demonstration project and a final report on such project within 6 months after the conclusion of the project. Such reports shall include recommendations regarding the expansion of the project to other areas and recommendations for such other legislative or administrative action as the Secretary determines appropriate.

(g) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section, $50,000,000.

SEC. 3102D. ENSURING PROPORTIONAL REPRESENTATION OF INTERESTS OF RURAL AREAS ON THE MEDICARE PAYMENT ADVISORY COMMISSION.

(a) IN GENERAL.—Section 1805(c)(2) of the Social Security Act (42 U.S.C. 1395b–6(c)(2)) is amended—

(1) in subparagraph (A), by inserting ''consistent with subparagraph (E)'' after ''rural representatives''; and

(2) by adding at the end the following new subparagraph:

''(E) PROPORTIONAL REPRESENTATION OF INTERESTS OF RURAL AREAS.—In order to provide a balance between urban and rural representatives under subparagraph (A), the proportion of members who represent the interests of health care providers and Medicare beneficiaries located in rural areas shall be no less than the proportion, of the total number of Medicare beneficiaries, who reside in rural areas.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to appointments made to the Medicare Payment Advisory Commission after the date of the enactment of this Act.

SEC. 3102E. IMPLEMENTATION OF GAO RECOMMENDATIONS REGARDING GEOGRAPHIC ADJUSTMENT INDICES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall implement the recommendations contained in the March 2005 GAO report 05–119 entitled ''Medicare Physician Fees: Geographic Adjustment Indices are Valid in Design, but Data and Methods Need Refinement.''.

SA 2861. Mr. FEINGOLD submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in subtitle C of title IV, insert the following:

SEC. 4___. AUTOMATED DEFIBRILLATION IN ADAM'S MEMORY ACT.

Section 312 of the Public Health Service Act (42 U.S.C. 244) is amended—

(1) in subsection (c)(6), after ''clearinghouse'' insert '', that shall be administered by an organization that has substantial expertise in pediatric education, pediatric medicine, and electrophysiology and sudden death,''; and

(2) in the first sentence of subsection (e), by striking ''fiscal year 2003'' and all that follows through ''2006'' and inserting ''for each of fiscal years 2003 through 2014''.

SA 2862. Mr. KOHL (for himself, Mr. GRASSLEY, Mr. FEINGOLD, Ms. KLOBUCHAR, Mr. FRANKEN, Mr. NELSON of Florida, and Mr. BROWN) submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—PRESERVE ACCESS TO AFFORDABLE GENERICS ACT

SEC. __01. SHORT TITLE.

This title may be cited as the ''Preserve Access to Affordable Generics Act''.

SEC. __02. UNLAWFUL COMPENSATION FOR DELAY.

(a) IN GENERAL.—The Federal Trade Commission Act (15 U.S.C. 44 et seq.) is amended by—

(1) redesignating section 28 as section 29; and

(2) inserting before section 29, as redesignated, the following:

''SEC. 28. PRESERVING ACCESS TO AFFORDABLE GENERICS.

''(a) IN GENERAL.—

''(1) ENFORCEMENT PROCEEDING.—The Federal Trade Commission may initiate a proceeding to enforce the provisions of this section against the parties to any agreement resolving or settling, on a final or interim basis, a patent infringement claim, in connection with the sale of a drug product.

''(2) PRESUMPTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), in such a proceeding, an agreement shall be presumed to have anticompetitive effects and be unlawful if—

''(i) an ANDA filer receives anything of value; and

''(ii) the ANDA filer agrees to limit or forego research, development, manufacturing, marketing, or sales of the ANDA product for any period of time.

''(B) EXCEPTION.—The presumption in subparagraph (A) shall not apply if the parties to such agreement demonstrate by clear and convincing evidence that the procompetitive benefits of the agreement outweigh the anticompetitive effects of the agreement.

''(b) COMPETITIVE FACTORS.—In determining whether the settling parties have met their burden under subsection (a)(2)(B), the fact finder shall consider—

''(1) the length of time remaining until the end of the life of the relevant patent, compared with the agreed upon entry date for the ANDA product;

''(2) the value to consumers of the competition from the ANDA product allowed under the agreement;

''(3) the form and amount of consideration received by the ANDA filer in the agreement resolving or settling the patent infringement claim;

''(4) the revenue the ANDA filer would have received by winning the patent litigation;

''(5) the reduction in the NDA holder's revenues if it had lost the patent litigation;

''(6) the time period between the date of the agreement conveying value to the ANDA filer and the date of the settlement of the patent infringement claim; and

''(7) any other factor that the fact finder, in its discretion, deems relevant to its determination of competitive effects under this subsection.

''(c) LIMITATIONS.—In determining whether the settling parties have met their burden under subsection (a)(2)(B), the fact finder shall not presume—

''(1) that entry would not have occurred until the expiration of the relevant patent or statutory exclusivity; or

''(2) that the agreement's provision for entry of the ANDA product prior to the expiration of the relevant patent or statutory exclusivity means that the agreement is procompetitive, although such evidence may be relevant to the fact finder's determination under this section.

''(d) EXCLUSIONS.—Nothing in this section shall prohibit a resolution or settlement of a patent infringement claim in which the consideration granted by the NDA holder to the ANDA filer as part of the resolution or settlement includes only one or more of the following:

''(1) The right to market the ANDA product in the United States prior to the expiration of—

''(A) any patent that is the basis for the patent infringement claim; or

''(B) any patent right or other statutory exclusivity that would prevent the marketing of such drug.

''(2) A payment for reasonable litigation expenses not to exceed $7,500,000.

''(3) A covenant not to sue on any claim that the ANDA product infringes a United States patent.

''(e) REGULATIONS AND ENFORCEMENT.—

''(1) REGULATIONS.—The Federal Trade Commission may issue, in accordance with section 553 of title 5, United States Code, regulations implementing and interpreting this section. These regulations may exempt certain types of agreements described in subsection (a) if the Commission determines such agreements will further market competition and benefit consumers. Judicial review of any such regulation shall be in the United States District Court for the District of Columbia pursuant to section 706 of title 5, United States Code.

''(2) ENFORCEMENT.—A violation of this section shall be treated as a violation of section 5.

''(3) JUDICIAL REVIEW.—Any person, partnership or corporation that is subject to a final order of the Commission, issued in an administrative adjudicative proceeding under the authority of subsection (a)(1), may, within 30 days of the issuance of such order, petition for review of such order in the United States Court of Appeals for the District of Columbia Circuit or the United States Court of Appeals for the circuit in which the ultimate parent entity, as defined at 16 C.F.R. 801.1(a)(3), of the NDA holder is incorporated as of the date that the NDA is filed with the Secretary of the Food and Drug Administration, or the United States Court of Appeals for the circuit in which the ultimate parent entity of the ANDA filer is incorporated as of the date that the ANDA is filed with the Secretary of the Food and Drug Administration. In such a review proceeding, the findings of the Commission as to the facts, if supported by evidence, shall be conclusive.

''(f) ANTITRUST LAWS.—Nothing in this section shall be construed to modify, impair or supersede the applicability of the antitrust laws as defined in subsection (a) of the 1st section of the Clayton Act (15 U.S.C. 12(a)) and of section 5 of this Act to the extent that

section 5 applies to unfair methods of competition. Nothing in this section shall modify, impair, limit or supersede the right of an ANDA filer to assert claims or counterclaims against any person, under the antitrust laws or other laws relating to unfair competition.

''(g) PENALTIES.—

''(1) FORFEITURE.—Each person, partnership or corporation that violates or assists in the violation of this section shall forfeit and pay to the United States a civil penalty sufficient to deter violations of this section, but in no event greater than 3 times the value received by the party that is reasonably attributable to a violation of this section. If no such value has been received by the NDA holder, the penalty to the NDA holder shall be shall be sufficient to deter violations, but in no event greater than 3 times the value given to the ANDA filer reasonably attributable to the violation of this section. Such penalty shall accrue to the United States and may be recovered in a civil action brought by the Federal Trade Commission, in its own name by any of its attorneys designated by it for such purpose, in a district court of the United States against any person, partnership or corporation that violates this section. In such actions, the United States district courts are empowered to grant mandatory injunctions and such other and further equitable relief as they deem appropriate.

''(2) CEASE AND DESIST.—

''(A) IN GENERAL.—If the Commission has issued a cease and desist order with respect to a person, partnership or corporation in an administrative adjudicative proceeding under the authority of subsection (a)(1), an action brought pursuant to paragraph (1) may be commenced against such person, partnership or corporation at any time before the expiration of one year after such order becomes final pursuant to section 5(g).

''(B) EXCEPTION.—In an action under subparagraph (A), the findings of the Commission as to the material facts in the administrative adjudicative proceeding with respect to such person's, partnership's or corporation's violation of this section shall be conclusive unless—

''(i) the terms of such cease and desist order expressly provide that the Commission's findings shall not be conclusive; or

''(ii) the order became final by reason of section 5(g)(1), in which case such finding shall be conclusive if supported by evidence.

''(3) CIVIL PENALTY.—In determining the amount of the civil penalty described in this section, the court shall take into account—

''(A) the nature, circumstances, extent, and gravity of the violation;

''(B) with respect to the violator, the degree of culpability, any history of violations, the ability to pay, any effect on the ability to continue doing business, profits earned by the NDA holder, compensation received by the ANDA filer, and the amount of commerce affected; and

''(C) other matters that justice requires.

''(4) REMEDIES IN ADDITION.—Remedies provided in this subsection are in addition to, and not in lieu of, any other remedy provided by Federal law. Nothing in this paragraph shall be construed to affect any authority of the Commission under any other provision of law.

''(h) DEFINITIONS.—In this section:

''(1) AGREEMENT.—The term 'agreement' means anything that would constitute an agreement under section 1 of the Sherman Act (15 U.S.C. 1) or section 5 of this Act.

''(2) AGREEMENT RESOLVING OR SETTLING A PATENT INFRINGEMENT CLAIM.—The term 'agreement resolving or settling a patent infringement claim' includes any agreement that is entered into within 30 days of the resolution or the settlement of the claim, or any other agreement that is contingent upon, provides a contingent condition for, or is otherwise related to the resolution or settlement of the claim.

''(3) ANDA.—The term 'ANDA' means an abbreviated new drug application, as defined under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

''(4) ANDA FILER.—The term 'ANDA filer' means a party who has filed an ANDA with the Food and Drug Administration.

''(5) ANDA PRODUCT.—The term 'ANDA product' means the product to be manufactured under the ANDA that is the subject of the patent infringement claim.

''(6) DRUG PRODUCT.—The term 'drug product' means a finished dosage form (e.g., tablet, capsule, or solution) that contains a drug substance, generally, but not necessarily, in association with 1 or more other ingredients, as defined in section 314.3(b) of title 21, Code of Federal Regulations.

''(7) NDA.—The term 'NDA' means a new drug application, as defined under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)).

''(8) NDA HOLDER.—The term 'NDA holder' means—

''(A) the party that received FDA approval to market a drug product pursuant to an NDA;

''(B) a party owning or controlling enforcement of the patent listed in the Approved Drug Products With Therapeutic Equivalence Evaluations (commonly known as the 'FDA Orange Book') in connection with the NDA; or

''(C) the predecessors, subsidiaries, divisions, groups, and affiliates controlled by, controlling, or under common control with any of the entities described in subparagraphs (A) and (B) (such control to be presumed by direct or indirect share ownership of 50 percent or greater), as well as the licensees, licensors, successors, and assigns of each of the entities.

''(9) PATENT INFRINGEMENT.—The term 'patent infringement' means infringement of any patent or of any filed patent application, extension, reissue, renewal, division, continuation, continuation in part, reexamination, patent term restoration, patents of addition and extensions thereof.

''(10) PATENT INFRINGEMENT CLAIM.—The term 'patent infringement claim' means any allegation made to an ANDA filer, whether or not included in a complaint filed with a court of law, that its ANDA or ANDA product may infringe any patent held by, or exclusively licensed to, the NDA holder of the drug product.

''(11) STATUTORY EXCLUSIVITY.—The term 'statutory exclusivity' means those prohibitions on the approval of drug applications under clauses (ii) through (iv) of section 505(c)(3)(E) (5- and 3-year data exclusivity), section 527 (orphan drug exclusivity), or section 505A (pediatric exclusivity) of the Federal Food, Drug, and Cosmetic Act .''.

(b) EFFECTIVE DATE.—Section 28 of the Federal Trade Commission Act, as added by this section, shall apply to all agreements described in section 28(a)(1) of that Act entered into after November 15, 2009. Section 28(g) of the Federal Trade Commission Act, as added by this section, shall not apply to agreements entered into before the date of enactment of this title.

SEC. __03. NOTICE AND CERTIFICATION OF AGREEMENTS.

(a) NOTICE OF ALL AGREEMENTS.—Section 1112(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (21 U.S.C. 355 note) is amended by—

(1) striking ''the Commission the'' and inserting the following: ''the Commission—

''(1) the'';

(2) striking the period and inserting ''; and''; and

(3) inserting at the end the following:

''(2) any other agreement the parties enter into within 30 days of entering into an agreement covered by subsection (a) or (b).''.

(b) CERTIFICATION OF AGREEMENTS.—Section 1112 of such Act is amended by adding at the end the following:

''(d) CERTIFICATION.—The Chief Executive Officer or the company official responsible for negotiating any agreement required to be filed under subsection (a), (b), or (c) shall execute and file with the Assistant Attorney General and the Commission a certification as follows: 'I declare that the following is true, correct, and complete to the best of my knowledge: The materials filed with the Federal Trade Commission and the Department of Justice under section 1112 of subtitle B of title XI of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, with respect to the agreement referenced in this certification: (1) represent the complete, final, and exclusive agreement between the parties; (2) include any ancillary agreements that are contingent upon, provide a contingent condition for, or are otherwise related to, the referenced agreement; and (3) include written descriptions of any oral agreements, representations, commitments, or promises between the parties that are responsive to subsection (a) or (b) of such section 1112 and have not been reduced to writing.'.''.

SEC. __04. FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.

Section 505(j)(5)(D)(i)(V) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 355(j)(5)(D)(i)(V)) is amended by inserting ''section 28 of the Federal Trade Commission Act or'' after ''that the agreement has violated''.

SEC. __05. COMMISSION LITIGATION AUTHORITY.

Section 16(a)(2) of the Federal Trade Commission Act (15 U.S.C. 56(a)(2)) is amended—

(1) in subparagraph (D), by striking ''or'' after the semicolon;

(2) in subparagraph (E), by inserting ''or'' after the semicolon; and

(3) inserting after subparagraph (E) the following:

''(F) under section 28;''.

SEC. __06. STATUTE OF LIMITATIONS.

The Commission shall commence any enforcement proceeding described in section 28 of the Federal Trade Commission Act, as added by section __02, except for an action described in section 28(g)(2) of the Federal Trade Commission Act, not later than 3 years after the date on which the parties to the agreement file the Notice of Agreement as provided by sections 1112(c)(2) and (d) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (21 U.S.C. 355 note).

SEC. __07. SEVERABILITY.

If any provision of this title, an amendment made by this title, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this title, the amendments made by this title, and the application of the provisions of such title or amendments to any person or circumstance shall not be affected thereby.

SA 2863. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other

purposes; which was ordered to lie on the table; as follows:

At the end, add the following:

TITLE X—IMPORTATION OF PRESCRIPTION DRUGS

SEC. 10001. SHORT TITLE.

This title may be cited as the ''Pharmaceutical Market Access Act of 2009''

SEC. 10002. PURPOSES.

The purposes of this title are to—

(1) give all Americans immediate relief from the outrageously high cost of pharmaceuticals;

(2) reverse the perverse economics of the American pharmaceutical market;

(3) allow the importation of prescription drugs only if the drugs and facilities where such drugs are manufactured are approved by the Food and Drug Administration, and to exclude pharmaceutical narcotics; and

(4) ensure continued integrity to the prescription drug supply of the United States by—

(A) requiring that imported prescription drugs be packaged and shipped using counterfeit-resistant technologies;

(B) requiring Internet pharmacies to register with the United States Government for Americans to verify authenticity before purchases over the Internet;

(C) requiring all foreign sellers to register with United States Government and submit to facility inspections by the Government without prior notice; and

(D) limiting the eligible countries from which prescription drugs may be imported to Canada, member countries of the European Union, and other highly industrialized nations with safe pharmaceutical infrastructures.

SEC. 10003. AMENDMENTS TO SECTION 804 OF THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.

(a) DEFINITIONS.—Section 804(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384(a)) is amended to read as follows:

''(a) DEFINITIONS.—In this section:

''(1) IMPORTER.—The term 'importer' means a pharmacy, group of pharmacies, pharmacist, or wholesaler.

''(2) PERMITTED COUNTRY.—The term 'permitted country' means Australia, Canada, Israel, Japan, New Zealand, Switzerland, South Africa, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxemburg, Netherlands, Portugal, Spain, Sweden, the United Kingdom, Iceland, Liechtenstein, and Norway, except that the Secretary—

''(A) may add a country, union, or economic area as a permitted country for purposes of this section if the Secretary determines that the country, union, or economic area has a pharmaceutical infrastructure that is substantially equivalent or superior to the pharmaceutical infrastructure of the United States, taking into consideration pharmacist qualifications, pharmacy storage procedures, the drug distribution system, the drug dispensing system, and market regulation; and

''(B) may remove a country, union, or economic area as a permitted country for purposes of this section if the Secretary determines that the country, union, or economic area does not have such a pharmaceutical infrastructure.

''(3) PHARMACIST.—The term 'pharmacist' means a person licensed by the relevant governmental authority to practice pharmacy, including the dispensing and selling of prescription drugs.

''(4) PHARMACY.—The term 'pharmacy' means a person that is licensed by the relevant governmental authority to engage in the business of selling prescription drugs that employs 1 or more pharmacists.

''(5) PRESCRIPTION DRUG.—The term 'prescription drug' means a drug subject to section 503(b), other than—

''(A) a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802));

''(B) a biological product (as defined in section 351 of the Public Health Service Act (42 U.S.C. 262));

''(C) an infused drug (including a peritoneal dialysis solution);

''(D) an intravenously injected drug;

''(E) a drug that is inhaled during surgery; or

''(F) a drug which is a parenteral drug, the importation of which pursuant to subsection (b) is determined by the Secretary to pose a threat to the public health, in which case section 801(d)(1) shall continue to apply.

''(6) QUALIFYING DRUG.—The term 'qualifying drug' means a prescription drug that—

''(A) is approved pursuant to an application submitted under section 505(b)(1); and

''(B) is not—

''(i) a drug manufactured through 1 or more biotechnology processes;

''(ii) a drug that is required to be refrigerated; or

''(iii) a photoreactive drug.

''(7) QUALIFYING INTERNET PHARMACY.—The term 'qualifying Internet pharmacy' means a registered exporter that dispenses qualifying drugs to individuals over an Internet Web site.

''(8) QUALIFYING LABORATORY.—The term 'qualifying laboratory' means a laboratory in the United States that has been approved by the Secretary for the purposes of this section.

''(9) REGISTERED EXPORTER.—The term 'registered exporter' means a person that is in the business of exporting a drug to persons in the United States (or that seeks to be in such business), for which a registration under this section has been approved and is in effect.

''(10) WHOLESALER.—

''(A) IN GENERAL.—The term 'wholesaler' means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A).

''(B) EXCLUSION.—The term 'wholesaler' does not include a person authorized to import drugs under section 801(d)(1).''.

(b) REGULATIONS.—Section 804(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384(b)) is amended to read as follows:

''(b) REGULATIONS.—Not later than 180 days after the date of enactment of the Pharmaceutical Market Access Act of 2009, the Secretary, after consultation with the United States Trade Representative and the Commissioner of the U.S. Customs and Border Protection, shall promulgate regulations permitting pharmacists, pharmacies, and wholesalers to import qualifying drugs from permitted countries into the United States.''.

(c) LIMITATION.—Section 804(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384(c)) is amended by striking ''prescription drug'' each place it appears and inserting ''qualifying drug''.

(d) INFORMATION AND RECORDS.—Section 804(d)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384(d)(1)) is amended—

(1) by striking subparagraph (G) and redesignating subparagraphs (H) through (N) as subparagraphs (G) through (M), respectively;

(2) in subparagraph (H) (as so redesignated), by striking ''telephone number, and professional license number (if any)'' and inserting ''and telephone number''; and

(3) in subparagraph (L) (as so redesignated), by striking ''(J) and (L)'' and inserting ''(I) and (K)''.

(e) TESTING.—Section 804(e) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384(e)) is amended to read as follows:

''(e) TESTING.—The regulations under subsection (b) shall require that the testing described under subparagraphs (I) and (K) of subsection (d)(1) be conducted by the importer of the qualifying drug, unless the qualifying drug is subject to the requirements under section 505E for counterfeit-resistant technologies.''.

(f) REGISTRATION OF EXPORTERS; INSPECTIONS.—Section 804(f) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384(f)) is amended to read as follows:

''(f) REGISTRATION OF EXPORTERS; INSPECTIONS.—

''(1) IN GENERAL.—Any person that seeks to be a registered exporter (referred to in this subsection as the 'registrant') shall submit to the Secretary a registration that includes the following:

''(A) The name of the registrant and identification of all places of business of the registrant that relate to qualifying drugs, including each warehouse or other facility owned or controlled by, or operated for, the registrant.

''(B) An agreement by the registrant to—

''(i) make its places of business that relate to qualifying drugs (including warehouses and other facilities owned or controlled by, or operated for, the exporter) and records available to the Secretary for on-site inspections, without prior notice, for the purpose of determining whether the registrant is in compliance with this Act's requirements;

''(ii) export only qualifying drugs;

''(iii) export only to persons authorized to import the drugs;

''(iv) notify the Secretary of a recall or withdrawal of a qualifying drug distributed in a permitted country to or from which the registrant has exported or imported, or intends to export or import, to the United States;

''(v) monitor compliance with registration conditions and report any noncompliance promptly;

''(vi) submit a compliance plan showing how the registrant will correct violations, if any; and

''(vii) promptly notify the Secretary of changes in the registration information of the registrant.

''(2) NOTICE OF APPROVAL OR DISAPPROVAL.—

''(A) IN GENERAL.—Not later than 90 days after receiving a completed registration from a registrant, the Secretary shall—

''(i) notify such registrant of receipt of the registration;

''(ii) assign such registrant a registration number; and

''(iii) approve or disapprove the application.

''(B) DISAPPROVAL OF APPLICATION.—

''(i) IN GENERAL.—The Secretary shall disapprove a registration, and notify the registrant of such disapproval, if the Secretary has reason to believe that such registrant is not in compliance with a registration condition.

''(ii) SUBSEQUENT APPROVAL.—The Secretary may subsequently approve a registration that was denied under clause (i) if the Secretary finds that the registrant is in compliance with all registration conditions.

''(3) LIST.—The Secretary shall—

''(A) maintain an up-to-date list of registered exporters (including qualifying Internet pharmacies that sell qualifying drugs to individuals);

''(B) make such list available to the public on the Internet Web site of the Food and Drug Administration and via a toll-free telephone number; and

''(C) update such list promptly after the approval of a registration under this subsection.

''(4) EDUCATION OF CONSUMERS.—The Secretary shall carry out activities, by use of the Internet Web site and toll-free telephone number under paragraph (3), that educate consumers with regard to the availability of qualifying drugs for import for personal use under this section, including information on how to verify whether an exporter is registered.

''(5) INSPECTION OF IMPORTERS AND REGISTERED EXPORTERS.—The Secretary shall inspect the warehouses, other facilities, and records of importers and registered exporters as often as the Secretary determines necessary to ensure that such importers and registered exporters are in compliance with this section.''.

(g) SUSPENSION OF IMPORTATION.—Section 804(g) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384(g)) is amended by—

(1) striking ''and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported under subsection (b)''; and

(2) by adding after the period at the end the following: ''The Secretary shall reinstate the importation by a specific importer upon a determination by the Secretary that the violation has been corrected and that the importer has demonstrated that further violations will not occur. This subsection shall not apply to a prescription drug imported by an individual, or to a prescription drug shipped to an individual by a qualifying Internet pharmacy.''.

(h) WAIVER AUTHORITY FOR INDIVIDUALS.—Section 804(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384(j)) is amended to read as follows:

''(j) IMPORTATION BY INDIVIDUALS.—

''(1) IN GENERAL.—Not later than 180 days after the enactment of the Pharmaceutical Market Access Act of 2009, the Secretary shall by regulation permit an individual to import a drug from a permitted country to the United States if the drug is—

''(A) a qualifying drug;

''(B) imported from a licensed pharmacy or qualifying Internet pharmacy;

''(C) for personal use by an individual, or family member of the individual, not for resale;

''(D) in a quantity that does not exceed a 90-day supply during any 90-day period; and

''(E) accompanied by a copy of a prescription for the drug, which—

''(i) is valid under applicable Federal and State laws; and

''(ii) was issued by a practitioner who is authorized to administer prescription drugs.

''(2) DRUGS DISPENSED OUTSIDE THE UNITED STATES.—An individual may import a drug from a country that is not a permitted country if—

''(A) the drug was dispensed to the individual while the individual was in such country, and the drug was dispensed in accordance with the laws and regulations of such country;

''(B) the individual is entering the United States and the drug accompanies the individual at the time of entry;

''(C) the drug is approved for commercial distribution in the country in which the drug was obtained;

''(D) the drug does not appear to be adulterated; and

''(E) the quantity of the drug does not exceed a 14-day supply.''.

(i) REPEAL OF CERTAIN PROVISIONS.—Section 804 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384) is amended by striking subsections (l) and (m).

SEC. 10004. REGISTRATION FEES.

Subchapter C of chapter VII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379f et seq.) is amended by adding at the end the following:

''PART 6—FEES RELATING TO PRESCRIPTION DRUG IMPORTATION

''SEC. 743. FEES RELATING TO PRESCRIPTION DRUG IMPORTATION.

''(a) REGISTRATION FEE.—The Secretary shall establish a registration fee program under which a registered exporter under section 804 shall be required to pay an annual fee to the Secretary in accordance with this subsection.

''(b) COLLECTION.—

''(1) COLLECTION ON INITIAL REGISTRATION.—A fee under this section shall be payable for the fiscal year in which the registered exporter first submits a registration under section 804 (or reregisters under that section if that person has withdrawn its registration and subsequently reregisters) in a amount of $10,000, due on the date the exporter first submits a registration to the Secretary under section 804.

''(2) COLLECTION IN SUBSEQUENT YEARS.—After the fee is paid for the first fiscal year, the fee described under this subsection shall be payable on or before October 1 of each year.

''(3) ONE FEE PER FACILITY.—The fee shall be paid only once for each registered exporter for a fiscal year in which the fee is payable.

''(c) FEE AMOUNT.—

''(1) IN GENERAL.—Subject to subsection (b)(1), the amount of the fee shall be determined each year by the Secretary and shall be based on the anticipated costs to the Secretary of enforcing the amendments made by the Pharmaceutical Market Access Act of 2009 in the subsequent fiscal year.

''(2) LIMITATION.—

''(A) IN GENERAL.—The aggregate total of fees collected under this section shall not exceed 1 percent of the total price of drugs exported annually to the United States by registered exporters under this section.

''(B) REASONABLE ESTIMATE.—Subject to the limitation described in subparagraph (A), a fee under this subsection for an exporter shall be an amount that is a reasonable estimate by the Secretary of the annual share of the exporter of the volume of drugs exported by exporters under this section.

''(d) USE OF FEES.—The fees collected under this section shall be used for the sole purpose of administering this section with respect to registered exporters, including the costs associated with—

''(1) inspecting the facilities of registered exporters, and of other entities in the chain of custody of a qualifying drug;

''(2) developing, implementing, and maintaining a system to determine registered exporters' compliance with the registration conditions under the Pharmaceutical Market Access Act of 2009, including when shipments of qualifying drugs are offered for import into the United States; and

''(3) inspecting such shipments, as necessary, when offered for import into the United States to determine if any such shipment should be refused admission.

''(e) ANNUAL FEE SETTING.—The Secretary shall establish, 60 days before the beginning of each fiscal year beginning after September 30, 2009, for that fiscal year, registration fees.

''(f) EFFECT OF FAILURE TO PAY FEES.—

''(1) DUE DATE.—A fee payable under this section shall be paid by the date that is 30 days after the date on which the fee is due.

''(2) FAILURE TO PAY.—If a registered exporter subject to a fee under this section fails to pay the fee, the Secretary shall not permit the registered exporter to engage in exportation to the United States or offering for exportation prescription drugs under this Act until all such fees owed by that person are paid.

''(g) REPORTS.—

''(1) FEE ESTABLISHMENT.—Not later than 60 days before the beginning of each fiscal year, the Secretary shall—

''(A) publish registration fees under this section for that fiscal year;

''(B) hold a meeting at which the public may comment on the recommendations; and

''(C) provide for a period of 30 days for the public to provide written comments on the recommendations.

''(2) PERFORMANCE AND FISCAL REPORT.—Beginning with fiscal year 2009, not later than 60 days after the end of each fiscal year during which fees are collected under this section, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that describes—

''(A) implementation of the registration fee authority during the fiscal year; and

''(B) the use by the Secretary of the fees collected during the fiscal year for which the report is made.''.

SEC. 10005. COUNTERFEIT-RESISTANT TECHNOLOGY.

(a) MISBRANDING.—Section 502 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352; deeming drugs and devices to be misbranded) is amended by adding at the end the following:

''(aa) If it is a drug subject to section 503(b), unless the packaging of such drug complies with the requirements of section 505E for counterfeit-resistant technologies.''.

(b) REQUIREMENTS.—Chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by inserting after section 505D the following:

''SEC. 505E. COUNTERFEIT-RESISTANT TECHNOLOGIES.

''(a) INCORPORATION OF COUNTERFEIT-RESISTANT TECHNOLOGIES INTO PRESCRIPTION DRUG PACKAGING.—The Secretary shall require that the packaging of any drug subject to section 503(b) incorporate—

''(1) overt optically variable counterfeit-resistant technologies that are described in subsection (b) and comply with the standards of subsection (c); or

''(2) technologies that have an equivalent function of security, as determined by the Secretary.

''(b) ELIGIBLE TECHNOLOGIES.—Technologies described in this subsection—

''(1) shall be visible to the naked eye, providing for visual identification of product authenticity without the need for readers, microscopes, lighting devices, or scanners;

''(2) shall be similar to that used by the Bureau of Engraving and Printing to secure United States currency;

''(3) shall be manufactured and distributed in a highly secure, tightly controlled environment; and

''(4) should incorporate additional layers of non-visible covert security features up to and including forensic capability.

''(c) STANDARDS FOR PACKAGING.—

''(1) MULTIPLE ELEMENTS.—For the purpose of making it more difficult to counterfeit the packaging of drugs subject to section 503(b), manufacturers of the drugs shall incorporate the technologies described in subsection (b) into multiple elements of the physical packaging of the drugs, including blister packs, shrink wrap, package labels, package seals, bottles, and boxes.

''(2) LABELING OF SHIPPING CONTAINER.—Shipments of drugs described in subsection (a) shall include a label on the shipping container that incorporates the technologies described in subsection (b), so that officials inspecting the packages will be able to determine the authenticity of the shipment. Chain of custody procedures shall apply to

such labels and shall include procedures applicable to contractual agreements for the use and distribution of the labels, methods to audit the use of the labels, and database access for the relevant governmental agencies for audit or verification of the use and distribution of the labels.

''(d) EFFECTIVE DATE.—This section shall take effect 180 days after the date of enactment of the Pharmaceutical Market Access Act of 2009.''.

SEC. 10006. PROHIBITED ACTS.

Section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331) is amended by inserting after subsection (k) the following:

''(l) The failure to register in accordance with section 804(f) or to import or offer to import a prescription drug in violation of a suspension order under section 804(g).''.

SEC. 10007. PATENTS.

Section 271 of title 35, United States Code, is amended—

(1) by redesignating subsections (h) and (i) as subsections (i) and (j), respectively; and

(2) by inserting after subsection (g) the following:

''(h) It shall not be an act of infringement to use, offer to sell, or sell within the United States or to import into the United States any patented invention under section 804 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384) that was first sold abroad by or under authority of the owner or licensee of such patent.''.

SEC. 10008. OTHER ENFORCEMENT ACTIONS.

(a) IN GENERAL.—Section 804 of the Federal Food, Drug, and Cosmetic Act, as amended by section 10003, is amended by adding at the end the following:

''(l) UNFAIR OR DISCRIMINATORY ACTS AND PRACTICES.—

''(1) IN GENERAL.—It is unlawful for a manufacturer, directly or indirectly (including by being a party to a licensing or other agreement) to—

''(A) discriminate by charging a higher price for a prescription drug sold to a person in a permitted country that exports a prescription drug to the United States under this section than the price that is charged to another person that is in the same country and that does not export a prescription drug into the United States under this section;

''(B) discriminate by charging a higher price for a prescription drug sold to a person that distributes, sells, or uses a prescription drug imported into the United States under this section than the price that is charged to another person in the United States that does not import a prescription drug under this section, or that does not distribute, sell, or use such a drug;

''(C) discriminate by denying supplies of a prescription drug to a person in a permitted country that exports a prescription drug to the United States under this section or distributes, sells, or uses a prescription drug imported into the United States under this section;

''(D) discriminate by publicly, privately, or otherwise refusing to do business with a person in a permitted country that exports a prescription drug to the United States under this section or distributes, sells, or uses a prescription drug imported into the United States under this section;

''(E) discriminate by specifically restricting or delaying the supply of a prescription drug to a person in a permitted country that exports a prescription drug to the United States under this section or distributes, sells, or uses a prescription drug imported into the United States under this section;

''(F) cause there to be a difference (including a difference in active ingredient, route of administration, dosage form, strength, formulation, manufacturing establishment, manufacturing process, or person that manufactures the drug) between a prescription drug for distribution in the United States and the drug for distribution in a permitted country for the purpose of restricting importation of the drug into the United States under this section;

''(G) refuse to allow an inspection authorized under this section of an establishment that manufactures a prescription drug that may be imported or offered for import under this section;

''(H) fail to conform to the methods used in, or the facilities used for, the manufacturing, processing, packing, or holding of a prescription drug that may be imported or offered for import under this section to good manufacturing practice under this Act;

''(I) become a party to a licensing or other agreement related to a prescription drug that fails to provide for compliance with all requirements of this section with respect to such prescription drug or that has the effect of prohibiting importation of the drug under this section; or

''(J) engage in any other action that the Federal Trade Commission determines to discriminate against a person that engages in, or to impede, delay, or block the process for, the importation of a prescription drug under this section.

''(2) AFFIRMATIVE DEFENSE.—It shall be an affirmative defense to a charge that a person has discriminated under subparagraph (A), (B), (C), (D), or (E) of paragraph (1) that the higher price charged for a prescription drug sold to a person, the denial of supplies of a prescription drug to a person, the refusal to do business with a person, or the specific restriction or delay of supplies to a person is not based, in whole or in part, on—

''(A) the person exporting or importing a prescription drug into the United States under this section; or

''(B) the person distributing, selling, or using a prescription drug imported into the United States under this section.

''(3) PRESUMPTION AND AFFIRMATIVE DEFENSE.—

''(A) PRESUMPTION.—A difference (including a difference in active ingredient, route of administration, dosage form, strength, formulation, manufacturing establishment, manufacturing process, or person that manufactures the drug) created after January 1, 2009, between a prescription drug for distribution in the United States and the drug for distribution in a permitted country shall be presumed under paragraph (1)(F) to be for the purpose of restricting importation of the drug into the United States under this section.

''(B) AFFIRMATIVE DEFENSE.—It shall be an affirmative defense to the presumption under subparagraph (A) that—

''(i) the difference was required by the country in which the drug is distributed; or

''(ii) the Secretary has determined that the difference was necessary to improve the safety or effectiveness of the drug.

''(4) EFFECT OF SUBSECTION.—

''(A) SALES IN OTHER COUNTRIES.—This subsection applies only to the sale or distribution of a prescription drug in a country if the manufacturer of the drug chooses to sell or distribute the drug in the country. Nothing in this subsection shall be construed to compel the manufacturer of a drug to distribute or sell the drug in a country.

''(B) DISCOUNTS TO INSURERS, HEALTH PLANS, PHARMACY BENEFIT MANAGERS, AND COVERED ENTITIES.—Nothing in this subsection shall be construed to—

''(i) prevent or restrict a manufacturer of a prescription drug from providing discounts to an insurer, health plan, pharmacy benefit manager in the United States, or covered entity in the drug discount program under section 340B of the Public Health Service Act (42 U.S.C. 256b) in return for inclusion of the drug on a formulary;

''(ii) require that such discounts be made available to other purchasers of the prescription drug; or

''(iii) prevent or restrict any other measures taken by an insurer, health plan, or pharmacy benefit manager to encourage consumption of such prescription drug.

''(C) CHARITABLE CONTRIBUTIONS.—Nothing in this subsection shall be construed to—

''(i) prevent a manufacturer from donating a prescription drug, or supplying a prescription drug at nominal cost, to a charitable or humanitarian organization, including the United Nations and affiliates, or to a government of a foreign country; or

''(ii) apply to such donations or supplying of a prescription drug.

''(5) ENFORCEMENT.—

''(A) UNFAIR OR DECEPTIVE ACT OR PRACTICE.—A violation of this subsection shall be treated as a violation of a rule defining an unfair or deceptive act or practice prescribed under section 18(a)(1)(B) of the Federal Trade Commission Act.

''(B) ACTIONS BY THE COMMISSION.—The Federal Trade Commission—

''(i) shall enforce this subsection in the same manner, by the same means, and with the same jurisdiction, powers, and duties as though all applicable terms and provisions of the Federal Trade Commission Act were incorporated into and made a part of this section; and

''(ii) may seek monetary relief threefold the damages sustained.

''(6) ACTIONS BY STATES.—

''(A) IN GENERAL.—

''(i) CIVIL ACTIONS.—The attorney general of a State may bring a civil action on behalf of the residents of the State, and persons doing business in the State, in a district court of the United States of appropriate jurisdiction for a violation of paragraph (1) to—

''(I) enjoin that practice;

''(II) enforce compliance with this subsection;

''(III) obtain damages, restitution, or other compensation on behalf of residents of the State and persons doing business in the State, including threefold the damages; or

''(IV) obtain such other relief as the court may consider to be appropriate.

''(ii) NOTICE.—

''(I) IN GENERAL.—Before filing an action under clause (i), the attorney general of the State involved shall provide to the Federal Trade Commission—

''(aa) written notice of that action; and

''(bb) a copy of the complaint for that action.

''(II) EXEMPTION.—Subclause (I) shall not apply with respect to the filing of an action by an attorney general of a State under this paragraph, if the attorney general determines that it is not feasible to provide the notice described in that subclause before filing of the action. In such case, the attorney general of a State shall provide notice and a copy of the complaint to the Federal Trade Commission at the same time as the attorney general files the action.

''(B) INTERVENTION.—

''(i) IN GENERAL.—On receiving notice under subparagraph (A)(ii), the Commission shall have the right to intervene in the action that is the subject of the notice.

''(ii) EFFECT OF INTERVENTION.—If the Commission intervenes in an action under subparagraph (A), it shall have the right—

''(I) to be heard with respect to any matter that arises in that action; and

''(II) to file a petition for appeal.

''(C) CONSTRUCTION.—For purposes of bringing any civil action under subparagraph (A),

nothing in this subsection shall be construed to prevent an attorney general of a State from exercising the powers conferred on the attorney general by the laws of that State to—

''(i) conduct investigations;

''(ii) administer oaths or affirmations; or

''(iii) compel the attendance of witnesses or the production of documentary and other evidence.

''(D) ACTIONS BY THE COMMISSION.—

''(i) IN GENERAL.—In any case in which an action is instituted by or on behalf of the Commission for a violation of paragraph (1), a State may not, during the pendency of that action, institute an action under subparagraph (A) for the same violation against any defendant named in the complaint in that action.

''(ii) INTERVENTION.—An attorney general of a State may intervene, on behalf of the residents of that State, in an action instituted by the Commission.

''(iii) EFFECT OF INTERVENTION.—If an attorney general of a State intervenes in an action instituted by the Commission, such attorney general shall have the right—

''(I) to be heard with respect to any matter that arises in that action; and

''(II) to file a petition for appeal.

''(E) VENUE.—Any action brought under subparagraph (A) may be brought in the district court of the United States that meets applicable requirements relating to venue under section 1391 of title 28, United States Code.

''(F) SERVICE OF PROCESS.—In an action brought under subparagraph (A), process may be served in any district in which the defendant—

''(i) is an inhabitant; or

''(ii) may be found.

''(G) LIMITATION OF ACTIONS.—Any action under this paragraph to enforce a cause of action under this subsection by the Federal Trade Commission or the attorney general of a State shall be forever barred unless commenced within 5 years after the Federal Trade Commission, or the attorney general, as the case may be, knew or should have known that the cause of action accrued. No cause of action barred under existing law on the effective date of the Pharmaceutical Market Access Act of 2009 shall be revived by such Act.

''(H) MEASUREMENT OF DAMAGES.—In any action under this paragraph to enforce a cause of action under this subsection in which there has been a determination that a defendant has violated a provision of this subsection, damages may be proved and assessed in the aggregate by statistical or sampling methods, by the computation of illegal overcharges or by such other reasonable system of estimating aggregate damages as the court in its discretion may permit without the necessity of separately proving the individual claim of, or amount of damage to, persons on whose behalf the suit was brought.

''(I) EXCLUSION ON DUPLICATIVE RELIEF.—The district court shall exclude from the amount of monetary relief awarded in an action under this paragraph brought by the attorney general of a State any amount of monetary relief which duplicates amounts which have been awarded for the same injury.

''(7) EFFECT ON ANTITRUST LAWS.—Nothing in this subsection shall be construed to modify, impair, or supersede the operation of the antitrust laws. For the purpose of this subsection, the term 'antitrust laws' has the meaning given it in the first section of the Clayton Act, except that it includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.

''(8) MANUFACTURER.—In this subsection, the term 'manufacturer' means any entity, including any affiliate or licensee of that entity, that is engaged in—

''(A) the production, preparation, propagation, compounding, conversion, or processing of a prescription drug, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis; or

''(B) the packaging, repackaging, labeling, relabeling, or distribution of a prescription drug.''.

(b) REGULATIONS.—The Federal Trade Commission shall promulgate regulations to carry out the enforcement program under section 804(l) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (a)).

(c) SUSPENSION AND TERMINATION OF EXPORTERS.—Section 804(g) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384(g)), as amended by section 10003(g), is amended by—

(1) striking ''SUSPENSION OF IMPORTATION.—The Secretary'' and inserting ''SUSPENSION OF IMPORTATION.—

''(1) IN GENERAL.—The Secretary''; and

(2) adding at the end the following:

''(2) SUSPENSION AND TERMINATION OF EXPORTERS.—

''(A) SUSPENSION.—With respect to the effectiveness of a registration submitted under subsection (f) by a registered exporter:

''(i) Subject to clause (ii), if the Secretary determines, after notice and opportunity for a hearing, that the registered exporter has failed to maintain substantial compliance with all registration conditions, the Secretary may suspend the registration.

''(ii) If the Secretary determines that, under color of the registration, the registered exporter has exported a drug that is not a qualifying drug, or a drug that does not meet the criteria under this section, or has exported a qualifying drug to an individual in violation of this section, the Secretary shall immediately suspend the registration. A suspension under the preceding sentence is not subject to the provision by the Secretary of prior notice, and the Secretary shall provide to the registered exporter involved an opportunity for a hearing not later than 10 days after the date on which the registration is suspended.

''(iii) The Secretary may reinstate the registration, whether suspended under clause (i) or (ii), if the Secretary determines that the registered exporter has demonstrated that further violations of registration conditions will not occur.

''(B) TERMINATION.—The Secretary, after notice and opportunity for a hearing, may terminate the registration under subsection (f) of a registered exporter if the Secretary determines that the registered exporter has engaged in a pattern or practice of violating 1 or more registration conditions, or if on 1 or more occasions the Secretary has under subparagraph (A)(ii) suspended the registration of the registered exporter. The Secretary may make the termination permanent, or for a fixed period of not less than 1 year. During the period in which the registration of a registered exporter is terminated, any registration submitted under subsection (f) by such exporter or a person who is a partner in the export enterprise or a principal officer in such enterprise, and any registration prepared with the assistance of such exporter or such a person, has no legal effect under this section.''.

SEC. 10009. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary to carry out this title (and the amendments made by this title).

SA 2864. Mr. VITTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 156, line 4, strike all through page 157, line 7, and insert the following:

(D) REQUIREMENT OF MEMBERS OF CONGRESS TO ENROLL IN THE PUBLIC OPTION.—

(i) REQUIREMENT.—Notwithstanding any other provision of law, all Members of Congress shall be enrolled in the community health insurance option when established by the Secretary.

(ii) INELIGIBLE FOR FEHBP.—Effective on the date on which the community health insurance option is established by the Secretary, no Member of Congress shall be eligible to participate in a health benefits plan under chapter 89 of title 5, United States Code.

(iii) EMPLOYER CONTRIBUTION.—

(I) IN GENERAL.—The Secretary of the Senate or the Chief Administrative Officer of the House of Representatives shall pay the amount determined under subclause (II) to—

(aa) the appropriate community health insurance option; or

(bb) in the case of a Member of Congress who resides in a State which opts out of providing a community health insurance option and is enrolled in a plan offered through an Exchange, the appropriate Exchange.

(II) AMOUNT OF EMPLOYER CONTRIBUTION.—The Director of the Office of Personnel Management shall determine the amount of the employer contribution for each Member of Congress enrolled in a community health insurance option. The amount shall be equal to the employer contribution for the health benefits plan under chapter 89 of title 5, United States Code, with the greatest number of enrollees, except that the contribution shall be actuarially adjusted for age.

(iv) MILITARY MEDICAL TREATMENT FACILITIES AND THE OFFICE OF THE ATTENDING PHYSICIAN.—

(I) IN GENERAL.—Notwithstanding any other provision of law, a Member of Congress may not receive health care or medical treatment at any military medical treatment facility or at the Office of the Attending Physician.

(II) EXCEPTION.—Subclause (I) shall not apply to any case of a medical emergency in which the life of a Member of Congress is in immediate danger.

(v) DEFINITIONS.—In this subparagraph:

(I) COMMUNITY HEALTH INSURANCE OPTION.—The term ''community health insurance option'' means the health insurance established by the Secretary under section 1323.

(II) MEMBER OF CONGRESS.—The term ''Member of Congress'' means any member of the House of Representatives or the Senate.

SA 2865. Mr. BURRIS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1249 between lines 6 and 7, insert the following:

(b) HOSPITAL COMPARE PATIENT SURVEYS.—

(1) IN GENERAL.—In implementing the Hospital Compare patient survey program, the Director of the Agency for Healthcare Research and Quality shall, in addition to collecting other information to reduce health disparities, collect information concerning—

(A) whether hospital staff effectively address cultural and linguistic barriers that may prevent patients from receiving quality health care; and

(B) whether hospital health promotion programs are effectively marketed in the community served by the hospital.

(2) REQUIREMENT TO TAKE INTO ACCOUNT SURVEY IN COMMUNITY HEALTH NEEDS ASSESSMENTS.—Section 501(r)(3)(B) of the Internal Revenue Code of 1986, as added by section 9007, is amended striking ''and'' at the end of clause (i), by redesignating clause (ii) as clause (iii), and by inserting after clause (i) the following new clause:

''(ii) takes into account the information collected under the Hospital Compare patient survey program, and''.

SA 2866. Mr. SPECTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle D of title IV, insert the following:

SEC. 4307. CURES ACCELERATION NETWORK.

(a) SHORT TITLE.—This section may be cited as the ''Cures Acceleration Network Act of 2009''.

(b) REQUIREMENT FOR THE DIRECTOR OF NIH TO ESTABLISH A CURES ACCELERATION NETWORK.—Section 402(b) of the Public Health Service Act (42 U.S.C. 282(b)) is amended—

(1) in paragraph (22), by striking ''and'' at the end;

(2) in paragraph (23), by striking the period and inserting ''; and''; and

(3) by inserting after paragraph (23), the following:

''(24) implement the Cures Acceleration Network described in section 402C.''.

(c) ACCEPTING GIFTS TO SUPPORT THE CURES ACCELERATION NETWORK.—Section 499(c)(1) of the Public Health Service Act (42 U.S.C. 290b(c)(1)) is amended by adding at the end the following:

''(E) The Cures Acceleration Network described in section 402C.''.

(d) ESTABLISHMENT OF THE CURES ACCELERATION NETWORK.—Part A of title IV of the Public Health Service Act is amended by inserting after section 402B (42 U.S.C. 282b) the following:

''SEC. 402C. CURES ACCELERATION NETWORK.

''(a) DEFINITIONS.—In this section:

''(1) BIOLOGICAL PRODUCT.—The term 'biological product' has the meaning given such term in section 351 of the Public Health Service Act.

''(2) DRUG; DEVICE.—The terms 'drug' and 'device' have the meanings given such terms in section 201 of the Federal Food, Drug, and Cosmetic Act.

''(3) HIGH NEED CURE.—The term 'high need cure' means a drug (as that term is defined by section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act, biological product (as that term is defined by section 262(i)), or device (as that term is defined by section 201(h) of the Federal Food, Drug, and Cosmetic Act) that, in the determination of the Director of NIH—

''(A) is a priority to diagnose, mitigate, prevent, or treat harm from any disease or condition; and

''(B) for which the incentives of the commercial market are unlikely to result in its adequate or timely development.

''(4) MEDICAL PRODUCT.—The term 'medical product' means a drug, device, biological product, or product that is a combination of drugs, devices, and biological products.

''(b) ESTABLISHMENT OF THE CURES ACCELERATION NETWORK.—Subject to the appropriation of funds as described in subsection (g), there is established within the Office of the Director of NIH a program to be known as the Cures Acceleration Network (referred to in this section as 'CAN'), which shall—

''(1) be under the direction of the Director of NIH, taking into account the recommendations of a CAN Review Board (referred to in this section as the 'Board'), described in subsection (d); and

''(2) award grants and contracts to eligible entities, as described in subsection (e), to accelerate the development of high need cures, including through the development of medical products and behavioral therapies.

''(c) FUNCTIONS.—The functions of the CAN are to—

''(1) conduct and support revolutionary advances in basic research, translating scientific discoveries from bench to bedside;

''(2) award grants and contracts to eligible entities to accelerate the development of high need cures;

''(3) provide the resources necessary for government agencies, independent investigators, research organizations, biotechnology companies, academic research institutions, and other entities to develop high need cures;

''(4) reduce the barriers between laboratory discoveries and clinical trials for new therapies; and

''(5) facilitate review in the Food and Drug Administration for the high need cures funded by the CAN, through activities that may include—

''(A) the facilitation of regular and ongoing communication with the Food and Drug Administration regarding the status of activities conducted under this section;

''(B) ensuring that such activities are coordinated with the approval requirements of the Food and Drug Administration, with the goal of expediting the development and approval of countermeasures and products; and

''(C) connecting interested persons with additional technical assistance made available under section 565 of the Federal Food, Drug, and Cosmetic Act.

''(d) CAN BOARD.—

''(1) ESTABLISHMENT.—There is established a Cures Acceleration Network Review Board (referred to in this section as the 'Board'), which shall advise the Director of NIH on the conduct of the activities of the Cures Acceleration Network.

''(2) MEMBERSHIP.—

''(A) IN GENERAL.—

''(i) APPOINTMENT.—The Board shall be comprised of 24 members who are appointed by the Secretary and who serve at the pleasure of the Secretary.

''(ii) CHAIRPERSON AND VICE CHAIRPERSON.—The Secretary shall designate, from among the 24 members appointed under clause (i), one Chairperson of the Board (referred to in this section as the 'Chairperson') and one Vice Chairperson.

''(B) TERMS.—

''(i) IN GENERAL.—Each member shall be appointed to serve a 4-year term, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed shall be appointed for the remainder of such term.

''(ii) CONSECUTIVE APPOINTMENTS; MAXIMUM TERMS.—A member may be appointed to serve not more than 3 terms on the Board, and may not serve more than 2 such terms consecutively.

''(C) QUALIFICATIONS.—

''(i) IN GENERAL.—The Secretary shall appoint individuals to the Board based solely upon the individual's established record of distinguished service in one of the areas of expertise described in clause (ii). Each individual appointed to the Board shall be of distinguished achievement and have a broad range of disciplinary interests.

''(ii) EXPERTISE.—The Secretary shall select individuals based upon the following requirements:

''(I) For each of the fields of—

''(aa) basic research;

''(bb) medicine;

''(cc) biopharmaceuticals;

''(dd) discovery and delivery of medical products;

''(ee) bioinformatics and gene therapy;

''(ff) medical instrumentation; and

''(gg) regulatory review and approval of medical products,

the Secretary shall select at least 1 individual who is eminent in such fields.

''(II) At least 4 individuals shall be recognized leaders in professional venture capital or private equity organizations and have demonstrated experience in private equity investing.

''(III) At least 8 individuals shall represent disease advocacy organizations.

''(3) EX-OFFICIO MEMBERS.—

''(A) APPOINTMENT.—In addition to the 24 Board members described in paragraph (2), the Secretary shall appoint as ex-officio members of the Board—

''(i) a representative of the National Institutes of Health, recommended by the Secretary of the Department of Health and Human Services;

''(ii) a representative of the Office of the Assistant Secretary of Defense for Health Affairs, recommended by the Secretary of Defense;

''(iii) a representative of the Office of the Under Secretary for Health for the Veterans Health Administration, recommended by the Secretary of Veterans Affairs;

''(iv) a representative of the National Science Foundation, recommended by the Chair of the National Science Board; and

''(v) a representative of the Food and Drug Administration, recommended by the Commissioner of Food and Drugs.

''(B) TERMS.—Each ex-officio member shall serve a 3-year term on the Board, except that the Chairperson may adjust the terms of the initial ex-officio members in order to provide for a staggered term of appointment for all such members.

''(4) RESPONSIBILITIES OF THE BOARD AND THE DIRECTOR OF NIH.—

''(A) RESPONSIBILITIES OF THE BOARD.—

''(i) IN GENERAL.—The Board shall advise, and provide recommendations to, the Director of NIH with respect to—

''(I) policies, programs, and procedures for carrying out the duties of the Director of NIH under this section; and

''(II) significant barriers to successful translation of basic science into clinical application (including issues under the purview of other agencies and departments).

''(ii) REPORT.—In the case that the Board identifies a significant barrier, as described in clause (i)(II), the Board shall submit to the Secretary a report regarding such barrier.

''(B) RESPONSIBILITIES OF THE DIRECTOR OF NIH.—With respect to each recommendation

provided by the Board under subparagraph (A)(i), the Director of NIH shall respond in writing to the Board, indicating whether such Director will implement such recommendation. In the case that the Director of NIH indicates a recommendation of the Board will not be implemented, such Director shall provide an explanation of the reasons for not implementing such recommendation.

''(5) MEETINGS.—

''(A) IN GENERAL.—The Board shall meet 4 times per calendar year, at the call of the Chairperson.

''(B) QUORUM; REQUIREMENTS; LIMITATIONS.—

''(i) QUORUM.—A quorum shall consist of a total of 13 members of the Board, excluding ex-officio members, with diverse representation as described in clause (iii).

''(ii) CHAIRPERSON OR VICE CHAIRPERSON.—Each meeting of the Board shall be attended by either the Chairperson or the Vice Chairperson.

''(iii) DIVERSE REPRESENTATION.—At each meeting of the Board, there shall be not less than one scientist, one representative of a disease advocacy organization, and one representative of a professional venture capital or private equity organization.

''(6) COMPENSATION AND TRAVEL EXPENSES.—

''(A) COMPENSATION.—Members shall receive compensation at a rate to be fixed by the Chairperson but not to exceed a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the performance of the duties of the Board. All members of the Board who are officers or employees of the Untied States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

''(B) TRAVEL EXPENSES.—Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for persons employed intermittently by the Federal Government under section 5703(b) of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

''(e) GRANT PROGRAM.—

''(1) SUPPORTING INNOVATION.—To carry out the purposes described in this section, the Director of NIH shall award contracts, grants, or cooperative agreements to the entities described in paragraph (2), to—

''(A) promote innovation in technologies supporting the advanced research and development and production of high need cures, including through the development of medical products and behavioral therapies;

''(B) accelerate the development of high need cures, including through the development of medical products, behavioral therapies, and biomarkers that demonstrate the safety or effectiveness of medical products; or

''(C) help the award recipient establish protocols that comply with Food and Drug Administration standards and otherwise permit the recipient to meet regulatory requirements at all stages of development, manufacturing, review, approval, and safety surveillance of a medical product.

''(2) ELIGIBLE ENTITIES.—To receive assistance under paragraph (1), an entity shall—

''(A) be a public or private entity, which may include a private or public research institution, an institution of higher education, a medical center, a biotechnology company, a pharmaceutical company, a disease advocacy organization, a patient advocacy organization, or an academic research institution;

''(B) submit an application containing—

''(i) a detailed description of the project for which the entity seeks such grant or contract;

''(ii) a timetable for such project;

''(iii) an assurance that the entity will submit—

''(I) interim reports describing the entity's—

''(aa) progress in carrying out the project; and

''(bb) compliance with all provisions of this section and conditions of receipt of such grant or contract; and

''(II) a final report at the conclusion of the grant period, describing the outcomes of the project; and

''(iv) a description of the protocols the entity will follow to comply with Food and Drug Administration standards and regulatory requirements at all stages of development, manufacturing, review, approval, and safety surveillance of a medical product; and

''(C) provide such additional information as the Director of NIH may require.

''(3) AWARDS.—

''(A) THE CURES ACCELERATION PARTNERSHIP AWARDS.—

''(i) INITIAL AWARD AMOUNT.—Each award under this subparagraph shall be not more than $15,000,000 per project for the first fiscal year for which the project is funded, which shall be payable in one payment.

''(ii) FUNDING IN SUBSEQUENT FISCAL YEARS.—An eligible entity receiving an award under clause (i) may apply for additional funding for such project by submitting to the Director of NIH the information required under subparagraphs (B) and (C) of paragraph (2). The Director may fund a project of such eligible entity in an amount not to exceed $15,000,000 for a fiscal year subsequent to the initial award under clause (i).

''(iii) MATCHING FUNDS.—As a condition for receiving an award under this subsection, an eligible entity shall contribute to the project non-Federal funds in the amount of $1 for every $3 awarded under clauses (i) and (ii), except that the Director of NIH may waive or modify such matching requirement in any case where the Director determines that the goals and objectives of this section cannot adequately be carried out unless such requirement is waived.

''(B) THE CURES ACCELERATION GRANT AWARDS.—

''(i) INITIAL AWARD AMOUNT.—Each award under this subparagraph shall be not more than $15,000,000 per project for the first fiscal year for which the project is funded, which shall be payable in one payment.

''(ii) FUNDING IN SUBSEQUENT FISCAL YEARS.—An eligible entity receiving an award under clause (i) may apply for additional funding for such project by submitting to the Board the information required under subparagraphs (B) and (C) of paragraph (2). The Director of NIH may fund a project of such eligible entity in an amount not to exceed $15,000,000 for a fiscal year subsequent to the initial award under clause (i).

''(C) THE CURES ACCELERATION FLEXIBLE RESEARCH AWARDS.—If the Director of NIH determines that the goals and objectives of this section cannot adequately be carried out through a contract, grant, or cooperative agreement, the Director of NIH shall have flexible research authority to use other transactions to fund projects in accordance with the terms and conditions of this section. Awards made under such flexible research authority for a fiscal year shall not exceed 20 percent of the total funds appropriated under subsection (g)(1) for such fiscal year.

''(4) SUSPENSION OF AWARDS FOR DEFAULTS, NONCOMPLIANCE WITH PROVISIONS AND PLANS, AND DIVERSION OF FUNDS; REPAYMENT OF FUNDS.—The Director of NIH may suspend the award to any entity upon noncompliance by such entity with provisions and plans under this section or diversion of funds.

''(5) AUDITS.—The Director of NIH may enter into agreements with other entities to conduct periodic audits of the projects funded by grants or contracts awarded under this subsection.

''(6) CLOSEOUT PROCEDURES.—At the end of a grant or contract period, a recipient shall follow the closeout procedures under section 74.71 of title 45, Code of Federal Regulations (or any successor regulation).

''(7) REVIEW.—A determination by the Director of NIH as to whether a drug, device, or biological product is a high need cure (for purposes of subsection (a)(3)) shall not be subject to judicial review.

''(f) COMPETITIVE BASIS OF AWARDS.—Any grant, cooperative agreement, or contract awarded under this section shall be awarded on a competitive basis.

''(g) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—For purposes of carrying out this section, there are authorized to be appropriated $500,000,000 for fiscal year 2010, and such sums as may be necessary for subsequent fiscal years. Funds appropriated under this section shall be available until expended.

''(2) LIMITATION ON USE OF FUNDS OTHERWISE APPROPRIATED.—No funds appropriated under this Act, other than funds appropriated under paragraph (1), may be allocated to the Cures Acceleration Network.''.

SA 2867. Mr. SPECTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title IV, insert the following:

SEC. ___. INCREASE IN FUNDING FOR THE NATIONAL INSTITUTES OF HEALTH.

(a) AUTHORIZATION OF APPROPRIATIONS.—Section 402A(a) of the Public Health Service Act (42 U.S.C. 282a(a)) is amended by striking paragraphs (1) through (3) and inserting the following:

''(1) $40,000,000,000 for fiscal year 2010; and

''(2) such sums as may be necessary for each of fiscal years 2011 and 2012.''.

(b) OFFICE OF THE DIRECTOR.—Section 402A(b) of the Public Health Service Act (42 U.S.C. 282a(b)) is amended by striking ''2007 through 2009'' and inserting ''2010 through 2012''.

SA 2868. Mr. BURRIS submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 147, line 19, strike ''and''.

On page 147, line 21, strike the period and insert ''; and''.

On page 147, between lines 21 and 22, insert the following:

''(E) the implementation of activities that reduce health care disparities, including through the use of language services, community outreach, and cultural competency training.''.

SA 2869. Mr. NELSON of Florida (for himself, Mr. ROCKEFELLER, Mr. BEGICH, Mr. LEAHY, Mr. BROWN, Ms. STABENOW, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 974, between lines 9 and 10, insert the following:

(b) ELIMINATION OF COVERAGE GAP.—Section 1860D–2(b) of the Social Security Act (42 U.S.C. 1395w–102(b)) is further amended—

(1) in paragraph (3)(A), by striking ''and (7)'' and inserting '', (7), and (8)'';

(2) in paragraph (4)(B)(i), by inserting ''subject to paragraph (8)'' after ''purposes of this part''; and

(3) by adding at the end the following new paragraph:

''(8) PHASED-IN ELIMINATION OF COVERAGE GAP.—

''(A) IN GENERAL.—For each year beginning with 2011, the Secretary shall consistent with this paragraph progressively increase the initial coverage limit (described in subsection (b)(3)) and decrease the annual out-of-pocket threshold from the amounts otherwise computed until there is a continuation of coverage from the initial coverage limit for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4).

''(B) INCREASE IN INITIAL COVERAGE LIMIT.—For a year beginning with 2011, the initial coverage limit otherwise computed without regard to this paragraph shall be increased by ½ of the cumulative phase-in percentage (as defined in subparagraph (D)(ii) for the year) times the out-of-pocket gap amount (as defined in subparagraph (E)) for the year.

''(C) DECREASE IN ANNUAL OUT-OF-POCKET THRESHOLD.—For a year beginning with 2011, the annual out-of-pocket threshold otherwise computed without regard to this paragraph shall be decreased by ½ of the cumulative phase-in percentage of the out-of-pocket gap amount for the year multiplied by 1.75.

''(D) PHASE–IN.—For purposes of this paragraph:

''(i) ANNUAL PHASE-IN PERCENTAGE.—The term 'annual phase-in percentage' means—

''(I) for 2011, 13 percent;

''(II) for 2012, 2013, 2014, and 2015, 5 percent;

''(III) for 2016 through 2018, 7.5 percent; and

''(IV) for 2019 and each subsequent year, 10 percent.

''(ii) CUMULATIVE PHASE-IN PERCENTAGE.—The term 'cumulative phase-in percentage' means for a year the sum of the annual phase-in percentage for the year and the annual phase-in percentages for each previous year beginning with 2011, but in no case more than 100 percent.

''(E) OUT-OF-POCKET GAP AMOUNT.—For purposes of this paragraph, the term 'out-of-pocket gap amount' means for a year the amount by which—

''(i) the annual out-of-pocket threshold specified in paragraph (4)(B) for the year (as determined as if this paragraph did not apply), exceeds

''(ii) the sum of—

''(I) the annual deductible under paragraph (1) for the year; and

''(II) ¼ of the amount by which the initial coverage limit under paragraph (3) for the year (as determined as if this paragraph did not apply) exceeds such annual deductible.''.

(c) REQUIRING DRUG MANUFACTURERS TO PROVIDE DRUG REBATES FOR FULL-BENEFIT DUAL ELIGIBLES.—

(1) IN GENERAL.—Section 1860D–2 of the Social Security Act (42 U.S.C. 1396r–8) is amended—

(A) in subsection (e)(1), in the matter before subparagraph (A), by inserting ''and subsection (f)'' after ''this subsection''; and

(B) by adding at the end the following new subsection:

''(f) PRESCRIPTION DRUG REBATE AGREEMENT FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

''(1) IN GENERAL.—In this part, the term 'covered part D drug' does not include any drug or biologic that is manufactured by a manufacturer that has not entered into and have in effect a rebate agreement described in paragraph (2).

''(2) REBATE AGREEMENT.—A rebate agreement under this subsection shall require the manufacturer to provide to the Secretary a rebate for each rebate period (as defined in paragraph (6)(B)) ending after December 31, 2010, in the amount specified in paragraph (3) for any covered part D drug of the manufacturer dispensed after December 31, 2010, to any full-benefit dual eligible individual (as defined in paragraph (6)(A)) for which payment was made by a PDP sponsor under part D or a MA organization under part C for such period. Such rebate shall be paid by the manufacturer to the Secretary not later than 30 days after the date of receipt of the information described in section 1860D–12(b)(7), including as such section is applied under section 1857(f)(3).

''(3) REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

''(A) IN GENERAL.—The amount of the rebate specified under this paragraph for a manufacturer for a rebate period, with respect to each dosage form and strength of any covered part D drug provided by such manufacturer and dispensed to a full-benefit dual eligible individual, shall be equal to the product of—

''(i) the total number of units of such dosage form and strength of the drug so provided and dispensed for which payment was made by a PDP sponsor under part D or a MA organization under part C for the rebate period (as reported under section 1860D–12(b)(7), including as such section is applied under section 1857(f)(3)); and

''(ii) the amount (if any) by which—

''(I) the Medicaid rebate amount (as defined in subparagraph (B)) for such form, strength, and period, exceeds

''(II) the average Medicare drug program full-benefit dual eligible rebate amount (as defined in subparagraph (C)) for such form, strength, and period.

''(B) MEDICAID REBATE AMOUNT.—For purposes of this paragraph, the term 'Medicaid rebate amount' means, with respect to each dosage form and strength of a covered part D drug provided by the manufacturer for a rebate period—

''(i) in the case of a single source drug or an innovator multiple source drug, the amount specified in paragraph (1)(A)(ii) of section 1927(b) plus the amount, if any, specified in paragraph (2)(A)(ii) of such section, for such form, strength, and period; or

''(ii) in the case of any other covered outpatient drug, the amount specified in paragraph (3)(A)(i) of such section for such form, strength, and period.

''(C) AVERAGE MEDICARE DRUG PROGRAM FULL-BENEFIT DUAL ELIGIBLE REBATE AMOUNT.—For purposes of this subsection, the term 'average Medicare drug program full-benefit dual eligible rebate amount' means, with respect to each dosage form and strength of a covered part D drug provided by a manufacturer for a rebate period, the sum, for all PDP sponsors under part D and MA organizations administering a MA–PD plan under part C, of—

''(i) the product, for each such sponsor or organization, of—

''(I) the sum of all rebates, discounts, or other price concessions (not taking into account any rebate provided under paragraph (2) for such dosage form and strength of the drug dispensed, calculated on a per-unit basis, but only to the extent that any such rebate, discount, or other price concession applies equally to drugs dispensed to full-benefit dual eligible Medicare drug plan enrollees and drugs dispensed to PDP and MA–PD enrollees who are not full-benefit dual eligible individuals; and

''(II) the number of the units of such dosage and strength of the drug dispensed during the rebate period to full-benefit dual eligible individuals enrolled in the prescription drug plans administered by the PDP sponsor or the MA–PD plans administered by the MA–PD organization; divided by

''(ii) the total number of units of such dosage and strength of the drug dispensed during the rebate period to full-benefit dual eligible individuals enrolled in all prescription drug plans administered by PDP sponsors and all MA–PD plans administered by MA–PD organizations.

''(4) LENGTH OF AGREEMENT.—The provisions of paragraph (4) of section 1927(b) (other than clauses (iv) and (v) of subparagraph (B)) shall apply to rebate agreements under this subsection in the same manner as such paragraph applies to a rebate agreement under such section.

''(5) OTHER TERMS AND CONDITIONS.—The Secretary shall establish other terms and conditions of the rebate agreement under this subsection, including terms and conditions related to compliance, that are consistent with this subsection.

''(6) DEFINITIONS.—In this subsection and section 1860D–12(b)(7):

''(A) FULL-BENEFIT DUAL ELIGIBLE INDIVIDUAL.—The term 'full-benefit dual eligible individual' has the meaning given such term in section 1935(c)(6).

''(B) REBATE PERIOD.—The term 'rebate period' has the meaning given such term in section 1927(k)(8).''.

(2) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURES RELATED TO REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

(A) REQUIREMENTS FOR PDP SPONSORS.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)) is amended by adding at the end the following new paragraph:

''(7) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURERS RELATED TO REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

''(A) IN GENERAL.—For purposes of the rebate under section 1860D–2(f) for contract years beginning on or after January 1, 2011, each contract entered into with a PDP sponsor under this part with respect to a prescription drug plan shall require that the sponsor comply with subparagraphs (B) and (C).

''(B) REPORT FORM AND CONTENTS.—Not later than 60 days after the end of each rebate period (as defined in section 1860D–2(f)(6)(B)) within such a contract year to which such section applies, a PDP sponsor of a prescription drug plan under this part shall report to each manufacturer—

''(i) information (by National Drug Code number) on the total number of units of each dosage, form, and strength of each drug of such manufacturer dispensed to full-benefit dual eligible Medicare drug plan enrollees under any prescription drug plan operated by the PDP sponsor during the rebate period;

''(ii) information on the price discounts, price concessions, and rebates for such drugs for such form, strength, and period;

''(iii) information on the extent to which such price discounts, price concessions, and rebates apply equally to full-benefit dual eligible Medicare drug plan enrollees and PDP enrollees who are not full-benefit dual eligible Medicare drug plan enrollees; and

''(iv) any additional information that the Secretary determines is necessary to enable the Secretary to calculate the average Medicare drug program full-benefit dual eligible rebate amount (as defined in paragraph (3)(C) of such section), and to determine the amount of the rebate required under this section, for such form, strength, and period.

Such report shall be in a form consistent with a standard reporting format established by the Secretary.

''(C) SUBMISSION TO SECRETARY.—Each PDP sponsor shall promptly transmit a copy of the information reported under subparagraph (B) to the Secretary for the purpose of audit oversight and evaluation.

''(D) CONFIDENTIALITY OF INFORMATION.—The provisions of subparagraph (D) of section 1927(b)(3), relating to confidentiality of information, shall apply to information reported by PDP sponsors under this paragraph in the same manner that such provisions apply to information disclosed by manufacturers or wholesalers under such section, except—

''(i) that any reference to 'this section' in clause (i) of such subparagraph shall be treated as being a reference to this section;

''(ii) the reference to the Director of the Congressional Budget Office in clause (iii) of such subparagraph shall be treated as including a reference to the Medicare Payment Advisory Commission; and

''(iii) clause (iv) of such subparagraph shall not apply.

''(E) OVERSIGHT.—Information reported under this paragraph may be used by the Inspector General of the Department of Health and Human Services for the statutorily authorized purposes of audit, investigation, and evaluations.

''(F) PENALTIES FOR FAILURE TO PROVIDE TIMELY INFORMATION AND PROVISION OF FALSE INFORMATION.—In the case of a PDP sponsor—

''(i) that fails to provide information required under subparagraph (B) on a timely basis, the sponsor is subject to a civil money penalty in the amount of $10,000 for each day in which such information has not been provided; or

''(ii) that knowingly (as defined in section 1128A(i)) provides false information under such subparagraph, the sponsor is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information.

Such civil money penalties are in addition to other penalties as may be prescribed by law. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(B) APPLICATION TO MA ORGANIZATIONS.—Section 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w–27(f)(3)) is amended by adding at the end the following:

''(D) REPORTING REQUIREMENT RELATED TO REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—Section 1860D–12(b)(7).''.

(3) DEPOSIT OF REBATES INTO MEDICARE PRESCRIPTION DRUG ACCOUNT.—Section 1860D–16(c) of such Act (42 U.S.C. 1395w–116(c)) is amended by adding at the end the following new paragraph:

''(6) REBATE FOR FULL-BENEFIT DUAL ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—Amounts paid under a rebate agreement under section 1860D–2(f) shall be deposited into the Account and shall be used to pay for all or part of the gradual elimination of the coverage gap under section 1860D–2(b)(7).''.

(d) SUNSET OF MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—Section 3301 of this Act is amended by adding at the end the following new subsection:

''(e) SUNSET OF MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—The amendments made by this section shall cease to be effective as of the date on which there is a continuation of coverage from the initial coverage limit for expenditures incurred through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4).''.

SA 2870. Mr. WHITEHOUSE proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. ___. SENSE OF THE SENATE PROMOTING FISCAL RESPONSIBILITY.

(a) FINDINGS.—The Senate makes the following findings:

(1) Based on Congressional Budget Office (CBO) estimates, this Act will reduce the Federal deficit between 2010 and 2019.

(2) CBO projects this Act will continue to reduce budget deficits after 2019.

(3) Based on CBO estimates, this Act will extend the solvency of the Medicare HI Trust Fund.

(4) This Act will increase the surplus in the Social Security Trust Fund, which should be reserved to strengthen the finances of Social Security.

(5) The initial net savings generated by the Community Living Assistance Services and Supports (CLASS) program are necessary to ensure the long-term solvency of that program.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the additional surplus in the Social Security Trust Fund generated by this Act should be reserved for Social Security and not spent in this Act for other purposes; and

(2) the net savings generated by the CLASS program should be reserved for the CLASS program and not spent in this Act for other purposes.

SA 2871. Mr. BROWN (for himself and Mrs. HUTCHISON) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 97, between lines 6 and 7, insert the following:

''SEC. 2710. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

''(a) COVERAGE.—

''(1) IN GENERAL.—If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides coverage to a qualified individual, then such plan or issuer—

''(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

''(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs; and

''(C) may not discriminate against the individual on the basis of the individual's participation in such trial.

''(2) ROUTINE PATIENT COSTS.—

''(A) INCLUSION.—For purposes of paragraph (1)(B), subject to subparagraph (B), routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial.

''(B) EXCLUSION.—For purposes of paragraph (1)(B), routine patient costs does not include—

''(i) the investigational item, device, or service, itself;

''(ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

''(iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

''(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(4) USE OF OUT-OF-NETWORK.—Notwithstanding paragraph (3), paragraph (1) shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the State in which the qualified individual resides.

''(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term 'qualified individual' means an individual who is a participant or beneficiary in a health plan or with coverage described in subsection (a)(1) and who meets the following conditions:

''(1) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.

''(2) Either—

''(A) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

''(B) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

''(c) LIMITATIONS ON COVERAGE.—This section shall not be construed to require a

group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine patient care services provided outside of the plan's (or coverage's) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).

''(d) APPROVED CLINICAL TRIAL DEFINED.—

''(1) IN GENERAL.—In this section, the term 'approved clinical trial' means a clinical trial (including a phase I, phase II, phase III, or phase IV trial) that is conducted in relation to the treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

''(A) The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

''(i) The National Institutes of Health.

''(ii) The Centers for Disease Control and Prevention.

''(iii) The Agency for Health Care Research and Quality.

''(iv) The Centers for Medicare & Medicaid Services.

''(v) A cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

''(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

''(vii) Any of the following if the conditions described in paragraph (2) are met:

''(I) The Department of Veterans Affairs.

''(II) The Department of Defense.

''(III) The Department of Energy.

''(B) The study or investigation is conducted in accordance with the requirements for investigational new drugs or investigational devices under the Federal Food, Drug, and Cosmetic Act.

''(C) The study or investigation is a clinical trial of a drug or device that is exempt from the requirements described under subparagraph (B).

''(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

''(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

''(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

''(e) LIFE-THREATENING CONDITION DEFINED.—In this section, the term 'life-threatening condition' means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

''(f) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

''(g) APPLICATION TO FEHBP.—Notwithstanding any provision of chapter 89 of title 5, United States Code, this section shall apply to health plans offered under the program under such chapter.

''(h) PREEMPTION.—Notwithstanding any other provision of this Act, nothing in this section shall preempt State laws that require a clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section.''.

SA 2872. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1465, between lines 12 and 13, insert the following:

SEC. 5506. COUNTING RESIDENT TIME IN CERTAIN HOSPITALS.

(a) GME.—Section 1886(h)(4) of the Social Security Act (42 U.S.C. 1395ww(h)(4)), as amended by sections 5504 and 5505, is amended—

(1) in subparagraph (E), by striking ''and (K)'' and inserting '', (K), and (L)''; and

(2) by adding at the end the following new subparagraph:

''(L) COUNTING RESIDENT TIME IN CERTAIN HOSPITALS.—

''(i) IN GENERAL.—Such rules shall provide that all the time spent by a resident under an approved medical training program in a hospital described in clause (ii) shall be counted toward the determination of full-time equivalency by the hospital that incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in the hospital described in clause (ii).

''(ii) HOSPITAL DESCRIBED.—A hospital described in this clause is a hospital that—

''(I) trains 3 or fewer full-time equivalent residents annually;

''(II) consents, not later than 1 year after the date on which the residents involved begin training under such approved medical training program (and annually thereafter), to forgo payments for direct graduate medical education costs under this subsection for such residents; and

''(III) has not had an approved FTE resident amount determined for the hospital under paragraph (2) as of the date on which such residents begin such training.''.

(b) IME.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)), as amended by section 5505, is amended by adding at the end the following new clause:

''(xi) The provisions of subparagraph (L) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.''.

(c) CONFORMING AMENDMENT.—Section 1886(h)(2) of such Act (42 U.S.C. 1395 ww(h)(2)) is amended by adding at the end the following new subparagraph:

''(G) EXCEPTION TO DETERMINATION OF PER RESIDENT AMOUNT.—The Secretary shall not determine an approved FTE resident amount under this paragraph for any hospital described in paragraph (4)(L)(ii).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after January 1, 2009.

SA 2873. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 1390, strike line 25 and all that follows through line 21 on page 1393, and insert the following:

''(4) to identify and refer underserved populations to appropriate healthcare agencies and community-based programs and organizations in order to increase access to quality healthcare services and to eliminate duplicative care; or

''(5) to educate, guide, and provide home visitation services regarding maternal health and prenatal care.

''(c) APPLICATION.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require.

''(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

''(1) propose to target geographic areas—

''(A) with a high percentage of residents who are eligible for health insurance but are uninsured or underinsured;

''(B) with a high percentage of residents who suffer from chronic diseases; or

''(C) with a high infant mortality rate;

''(2) have experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

''(3) have documented community activity and experience with community health workers.

''(e) COLLABORATION WITH ACADEMIC INSTITUTIONS AND THE ONE-STOP DELIVERY SYSTEM.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions and one-stop delivery systems under section 134(c) of the Workforce Investment Act of 1998. Nothing in this section shall be construed to require such collaboration.

''(f) EVIDENCE-BASED INTERVENTIONS.—The Secretary shall encourage community health worker programs receiving funding under this section to implement a process or an outcome-based payment system that rewards community health workers for connecting underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such a payment.

''(g) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers under the programs funded under this section and for assuring the cost-effectiveness of such programs.

''(h) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications under this section and shall determine whether such programs are in compliance with the guidelines established under subsection (g).

''(i) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such sums as may be necessary to carry out this section for each of fiscal years 2010 through 2014.

''(k) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who promotes health or nutrition within the community in which the individual resides—

SA 2874. Mr. BROWN submitted an amendment intended to be proposed to

amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1069, line 1, insert ''community health workers,'' after ''social workers,''.

SA 2875. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 536, line 10, insert ''community health worker,'' after ''social worker,''.

SA 2876. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. WAIVER OF MEDICARE DME SURETY BOND REQUIREMENT FOR CERTAIN DME SUPPLIERS.

Section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) is amended by adding at the end the following new sentence: ''The requirement for a surety bond described in subparagraph (B) shall not apply in the case of a pharmacy or supplier that exclusively provides eyeglasses or contact lenses as described in section 1861(s)(8) that (i) is enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies and has been issued (which may include renewal of) a provider number (as described in the first sentence of this paragraph) for at least 5 years, and (ii) for which a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has never been imposed.''.

SA 2877. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 869, between lines 14 and 15, insert the following:

SEC. 3143. REIMBURSEMENT FOR TOTAL BODY ORTHOTIC MANAGEMENT FOR CERTAIN NURSING HOME PATIENTS.

(a) IN GENERAL.—Not later than 60 days after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall issue product codes that qualified practitioners and suppliers may use to receive reimbursement under section 1834(h) of the Social Security Act (42 U.S.C. 1395m(h)) for qualified total body orthotic management devices used for the treatment of nonambulatory individuals with severe musculoskeletal conditions who are in the full-time care of skilled nursing facilities (as defined in section 1861(j) of such Act (42 U.S.C. 1395x(j))). In issuing such codes, the Secretary shall take all steps necessary to prevent fraud and abuse.

(b) QUALIFIED TOTAL BODY ORTHOTIC MANAGEMENT DEVICE.—For purposes of this section, the term ''qualified total body orthotic management device'' means a medically-prescribed device which—

(1) consists of custom fitted individual braces with adjustable points at the hips, knee, ankle, elbow, and wrist, but only if—

(A) the individually adjustable braces are attached to a frame which is an integral component of the device and cannot function or be used apart from the frame; and

(B) the frame is designed such that it serves no purpose without the braces; and

(2) is designed to—

(A) improve function;

(B) retard progression of musculoskeletal deformity; or

(C) restrict, eliminate, or assist in the functioning of lower and upper extremities and pelvic, spinal, and cervical regions of the body affected by injury, weakness, or deformity, of an individual for whom stabilization of affected areas of the body, or relief of pressure points, is required for medical reasons.

SA 2878. Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ___MINORITY HEALTH

SEC. ___01. OFFICE OF MINORITY HEALTH.

(a) IN GENERAL.—Section 1707 of the Public Health Service Act (42 U.S.C. 300u–6) is amended—

(1) in subsection (a), by striking ''within the Office of Public Health and Science and all that follows through the end'' and inserting ''. The Office of Minority Health as existing on the date of enactment of the Patient Protection and Affordable Care Act shall be transferred to the Office of the Secretary in such manner that there is established in the Office of the Secretary, the Office of Minority Health, which shall be headed by the Deputy Assistant Secretary for Minority Health who shall report directly to the Secretary, and shall retain and maintain an Advisory Committee on Minority Health as provided for under subsection (c).'' and

(2) by striking subsection (b) and inserting the following:

''(b) DUTIES.—With respect to improving the health of racial and ethnic minority groups, the Secretary, acting through the Deputy Assistant Secretary, shall carry out the following:

''(1) Establish, implement, monitor, and evaluate short-range and long-range goals and objectives and oversee all other activities within the Public Health Service that relate to disease prevention, health promotion, service delivery, and research concerning minority groups. The heads of each of the agencies of the Service shall consult with the Deputy Assistant Secretary to ensure the coordination of such activities.

''(2) Oversee all activities within the Department of Health and Human Services that relate to reducing or eliminating disparities in health and health care in racial and ethnic minority populations and in rural and underserved communities, including coordinating—

''(A) the design of programs, support for programs, and the evaluation of programs;

''(B) the monitoring of trends in health and health care;

''(C) research efforts;

''(D) the training of health providers; and

''(E) information and education programs and campaigns.

''(3) Enter into interagency and intra-agency agreements with other agencies of the Public Health Service.

''(4) Ensure that the Federal health agencies and the National Center for Health Statistics collect data on the health status and health care of each minority group, using at a minimum the categories specified in the 1997 OMB Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity as required under subtitle B and available language standards.

''(5) Provide technical assistance to States, local agencies, territories, Indian tribes, and entities for activities relating to the elimination of racial and ethnic disparities in health and health care.

''(6) Support a national minority health resource center to carry out the following:

''(A) Facilitate the exchange of information regarding matters relating to health information, health promotion and wellness, preventive health services, clinical trials, health information technology, and education in the appropriate use of health services.

''(B) Facilitate timely access to culturally and linguistically appropriate information.

''(C) Assist in the analysis of such information.

''(D) Provide technical assistance with respect to the exchange of such information (including facilitating the development of materials for such technical assistance).

''(7) Carry out programs to improve access to health care services for individuals with limited English proficiency.

''(8) Carry out programs to improve access to health care services and to improve the quality of health care services for individuals with low functional health literacy. As used in the preceding sentence, the term 'functional health literacy' means the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

''(9) Advise in matters related to the development, implementation, and evaluation of health professions education on decreasing disparities in health care outcomes, with focus on cultural competency as a method of eliminating disparities in health and health care in racial and ethnic minority populations.

''(10) Assist health care professionals, community and advocacy organizations, academic centers and public health departments in the design and implementation of programs that will improve the quality of health outcomes by strengthening the provider-patient relationship.

''(11) In carrying our this subsection—

''(A) award grants, contracts, enter into memoranda of understanding, cooperative,

interagency, intra-agency and other agreements with public and nonprofit private entities, agencies, as well as Departmental and Cabinet agencies and organizations; and

''(B) award grants, contracts, enter into memoranda of understanding, cooperative and other agreements with organizations that are indigenous human resource providers in communities of color to assure improved health status of racial and ethnic minorities.

''(12) Directly or through contracts with public and private entities, agencies, and nonprofit organizations, provide for evaluations of projects carried out with awards made the Office and for the dissemination of information developed as a result of such projects.'';

(3) by redesignating subsections (f) through (h) as subsections (g) through (i), respectively;

(4) by inserting after subsection (e) the following:

''(f) PREPARATION OF HEALTH PROFESSIONALS TO PROVIDE HEALTH CARE TO MINORITY POPULATIONS.—The Secretary, in collaboration with the Director of the Bureau of Health Professions and the Deputy Assistant Secretary for Minority Health, shall require that health professional schools that receive Federal funds train future health professionals to provide culturally and linguistically appropriate health care to diverse populations.''; and

(5) by striking subsection (i) (as so redesignated) and inserting the following:

''(i) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2016.''.

(b) TRANSFER OF FUNCTIONS.—There are transferred to the Office of Minority Health in the office of the Secretary of Health and Human Services, the Deputy Assistant Secretary for Minority Health who shall report directly to the Secretary of Health and Human Services. All duties, responsibilities, accountabilities and functions exercised by the Deputy Assistant Secretary for Minority Health and by the Office of Minority Health of the Public Health Service prior to the date of enactment of this section shall transfer with the Office and the Deputy Assistant Secretary for Minority Health, including all personnel and compensation authority, all delegation and assignment authority, all committees including the Advisory Committee on Minority Health and other committees, entities and councils, and all remaining appropriations. All orders, determinations, rules, regulations, permits, agreements, grants, contracts, certificates, licenses, registrations, privileges, and other administrative actions that—

(1) have been issued, made, granted, or allowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the performance of functions transferred under this paragraph; and

(2) transfers with the Deputy Assistant Secretary for Minority Health are in effect at the time this section takes effect, or were final before the date of enactment of this section and are to become effective on or after such date, transfers with and to the Office of Minority Health within the Office of the Secretary and remain the authority, responsibility and accountability of the Office; shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Secretary, a court of competent jurisdiction, or by operation of law.

(c) REPORTS.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this section, and every second year thereafter, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under section 1707 of the Public Health Service Act (as amended by this section) during the period for which the report is being prepared.

(2) AGENCY REPORTS.—Not later than 1 year after the date of enactment of this section, and biennially thereafter, the heads of each of the agencies of the Public Health Service shall submit to the Deputy Assistant Secretary for Minority Health a report summarizing the minority health activities of each of the respective agencies.

SEC. ___02. ESTABLISHMENT OF INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN AGENCIES OF THE PUBLIC HEALTH SERVICE.

Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by inserting after section 1707 the following section:

''SEC. 1707A. INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN PUBLIC HEALTH SERVICE.

''(a) IN GENERAL.—The head of each agency specified in subsection (b)(1) shall establish within the agency an office to be known as the Office of Minority Health. The head of each such Office shall be appointed by the head of the agency within which the Office is established, and shall report directly to the head of the agency. The head of such agency shall carry out this section (as this section relates to the agency) acting through such Director.

''(b) SPECIFIED AGENCIES.—

''(1) IN GENERAL.—The agencies referred to in subsection (a) are the following:

''(A) The Centers for Disease Control and Prevention.

''(B) The Health Resources and Services Administration.

''(C) The Substance Abuse and Mental Health Services Administration.

''(D) The Agency for Healthcare Research and Quality.

''(E) The Food and Drug Administration.

''(c) COMPOSITION.—The head of each specified agency shall ensure that the officers and employees of the minority health office of the agency are, collectively, experienced in carrying out community-based health programs for each of the various racial and ethnic minority groups that are present in significant numbers in the United States.

''(d) DUTIES.—Each head of a minority health office shall establish and monitor the programs of the specified agency of such office in order to carry out the following:

''(1) Determine the extent to which the purposes of the programs are being carried out with respect to racial and ethnic minority groups;

''(2) Determine the extent to which members of such groups are represented among the Federal officers and employees who administer the programs; and

''(3) Make recommendations to the head of such agency on carrying out the programs with respect to such groups. In the case of programs that provide services, such recommendations shall include recommendations toward ensuring that—

''(A) the services are equitably delivered with respect to racial and ethnic minority groups; and

''(B) the programs provide the services in the language and cultural context that is most appropriate for the individuals for whom the services are intended.

''(e) FUNDING.—

''(1) ALLOCATIONS.—Of the amounts appropriated for a specified agency for a fiscal year, the Secretary must designate an appropriate amount of funds for the purpose of carrying out activities under this section through the minority health office of the agency. In reserving an amount under the preceding sentence for a minority health office for a fiscal year, the Secretary shall reduce, by substantially the same percentage, the amount that otherwise would be available for each of the programs of the designated agency involved.

''(2) AVAILABILITY OF FUNDS FOR STAFFING.—The purposes for which amounts made available under paragraph may be expended by a minority health office include the costs of employing staff for such office.''.

SEC. ___03. OFFICE OF MINORITY HEALTH AT THE CENTERS FOR MEDICARE & MEDICAID SERVICES.

(a) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services shall establish within the Centers for Medicare & Medicaid Services an Office of Minority Health (referred to in this section as the ''Office'').

(b) DUTIES.—The Office shall be responsible for the coordination and facilitation of activities of the Centers for Medicare & Medicaid Services to improve minority health and health care and to reduce racial and ethnic disparities in health and health care, which shall include—

(1) creating a strategic plan, which shall be made available for public review, to improve the health and health care of Medicare, Medicaid, and SCHIP beneficiaries;

(2) promoting agency-wide policies relating to health care delivery and financing that could have a beneficial impact on the health and health care of minority populations;

(3) assisting health plans, hospitals, and other health entities in providing culturally and linguistically appropriate health care services;

(4) increasing awareness and outreach activities for minority health care consumers and providers about the causes and remedies for health and health care disparities;

(5) developing grant programs and demonstration projects to identify, implement and evaluate innovative approaches to improving the health and health care of minority beneficiaries in the Medicare, Medicaid, and SCHIP programs;

(6) considering incentive programs relating to reimbursement that would reward health entities for providing quality health care for minority populations using established benchmarks for quality of care;

(7) collaborating with the compliance office to ensure compliance with the anti-discrimination provisions under title VI of the Civil Rights Act of 1964;

(8) identifying barriers to enrollment in public programs under the jurisdiction of the Centers for Medicare & Medicaid Services;

(9) monitoring and evaluating on a regular basis the success of minority health programs and initiatives;

(10) publishing an annual report about the activities of the Centers for Medicare & Medicaid Services relating to minority health improvement; and

(11) other activities determined appropriate by the Secretary of Health and Human Services.

(c) STAFF.—The staff at the Office shall include—

(1) one or more individuals with expertise in minority health and racial and ethnic health disparities; and

(2) one or more individuals with expertise in health care financing and delivery in underserved communities.

(d) COORDINATION.—In carrying out its duties under this section, the Office shall coordinate with—

(1) the Office of Minority Health in the Office of the Secretary of Health and Human Services;

(2) the National Institute for Minority Health and Health Disparities (as so redesignated by section __05) in the National Institutes of Health; and

(3) the Office of Minority Health in the Centers for Disease Control and Prevention.

(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums may be necessary for each of fiscal years 2011 through 2016.

SEC. ___04. OFFICE OF MINORITY AFFAIRS AT THE FOOD AND DRUG ADMINISTRATION.

Chapter X of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended by adding at the end the following:

"SEC. 1011. OFFICE OF MINORITY AFFAIRS.

''(a) IN GENERAL.—Not later than 60 days after the date of enactment of this section, the Secretary shall establish within the Office of the Commissioner of Food and Drugs an Office of Minority Affairs (referred to in this section as the 'Office').

''(b) DUTIES.—The Office shall be responsible for the coordination and facilitation of activities of the Food and Drug Administration to improve minority health and health care and to reduce racial and ethnic disparities in health and health care, which shall include—

''(1) promoting policies in the development and review of medical products that reduce racial and ethnic disparities in health and health care;

''(2) encouraging appropriate data collection, analysis, and dissemination of racial and ethnic differences using, at a minimum, the categories described in the 1997 Office of Management and Budget standards, in response to different therapies in both adult and pediatric populations;

''(3) providing, in coordination with other appropriate government agencies, education, training, and support to increase participation of minority patients and physicians in clinical trials;

''(4) collecting and analyzing data using, at a minimum, the categories described in the 1997 Office of Management and Budget standards, on the number of participants from minority racial and ethnic backgrounds in clinical trials used to support medical product approvals;

''(5) the identification of methods to reduce language and literacy barriers; and

''(6) publishing an annual report about the activities of the Food and Drug Administration pertaining to minority health.

''(c) STAFF.—The staff of the Office shall include—

''(1) one or more individuals with expertise in the design and conduct of clinical trials of drugs, biological products, and medical devices; and

''(2) one or more individuals with expertise in therapeutic classes or disease states for which medical evidence suggests a difference based on race or ethnicity.

''(d) COORDINATION.—In carrying out its duties under this section, the Office shall coordinate with—

''(1) the Office of Minority Health in the Office of the Secretary of Health and Human Services;

''(2) the National Institute for Minority Health and Health Disparities in the National Institutes of Health; and

''(3) the Office of Minority Health in the Centers for Disease Control and Prevention.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2011 through 2016.''.

SEC. ___05. NATIONAL INSTITUTE FOR MINORITY HEALTH AND HEALTH DISPARITIES.

(a) REDESIGNATION.—

(1) IN GENERAL.—Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended—

(A) in section 401(b)(24), by striking ''National Center on Minority Health and Health Disparities'' and inserting ''National Institute for Minority Health and Health Disparities''; and

(B) in subpart 6 of part E—

(i) in the subpart heading, by striking ''Center'' and inserting ''Institute'';

(ii) in the headings of sections 485E and 485H, by striking ''**CENTER**'' and inserting ''**INSTITUTE**''; and

(iii) by striking (other than in section 485E(i)(1)) the term ''Center'' each place it appears and inserting ''Institute''.

(2) REFERENCES.—Any reference in any law, map, regulation, document, paper, or other record of the United States to the National Center on Minority Health and Health Disparities shall be deemed to be a reference to the National Institute for Minority Health and Health Disparities.

(b) DUTIES; AUTHORITIES; FUNDING.—Section 485E of the Public Health Service Act (42 U.S.C. 287c–31) is amended—

(1) by amending subsection (e) to read as follows:

''(e) DUTIES OF THE DIRECTOR.—

''(1) INTERAGENCY COORDINATION OF MINORITY HEALTH AND HEALTH DISPARITY ACTIVITIES.—With respect to minority health and health disparities, the Director of the Institute shall plan, coordinate, and evaluate research and other activities conducted or supported by the institutes and centers of the National Institutes of Health. In carrying out the preceding sentence, the Director of the Institute shall evaluate the minority health and health disparity activities of each of such institutes and centers and shall provide for the periodic reevaluation of such activities. Such institutes and centers shall be responsible for providing information to the Institute, including data on clinical trials funded or conducted by these institutes and centers.

''(2) CONSULTATIONS.—The Director of the Institute shall carry out this subpart (including developing and revising the plan and budget required by subsection (f) in consultation with the heads of the institutes and centers of the National Institutes of Health, the advisory councils of such institutes and centers, and the advisory council established pursuant to subsection (j).

''(3) COORDINATION OF ACTIVITIES.—The Director of the Institute—

''(A) shall act as the primary Federal official with responsibility for coordinating all research and activities conducted or supported by the National Institutes of Health on minority or other health disparities;

''(B) shall represent the health disparities research program of the National Institutes of Health, including the minority health and other health disparities research program, at all relevant executive branch task forces, committees, and planning activities; and

''(C) shall maintain communications with all relevant agencies of the Public Health Service, including the Indian Health Service, and various other departments and agencies of the Federal Government to ensure the timely transmission of information concerning advances in minority health disparities research and other health disparities research among these various agencies for dissemination to affected communities and health care providers.'';

(2) by amending subsection (f) to read as follows:

''(f) STRATEGIC PLAN.—

''(1) IN GENERAL.—Subject to the provisions of this section and other applicable law, the Director of the Institute, in consultation with the Director of NIH, the Directors of the other institutes and centers of the National Institutes of Health, and the advisory council established pursuant to subsection (j), shall—

''(A) annually review and revise a strategic plan (referred to in this section as 'the plan') and budget for the conduct and support of all minority health disparity research and other health disparity research activities of the institutes and centers of the National Institutes of Health that include time-based targeted objectives with measurable outcomes and assure that the annual review and revision of the plan uses an established trans-National Institutes of Health process subject to timely review, approval, and dissemination;

''(B) ensure that the plan and budget establish priorities among the health disparities research activities that such agencies are authorized to carry out;

''(C) ensure that the plan and budget establish objectives regarding such activities, describe the means for achieving the objectives, and designate the date by which the objectives are expected to be achieved;

''(D) ensure that all amounts appropriated for such activities are expended in accordance with the plan and budget;

''(E) annually submit to Congress a report on the progress made with respect to the plan; and

''(F) create and implement a plan for the systemic review of research activities supported by the National Institutes of Health that are within the mission of both the Institute and other institutes and centers of the National Institutes of Health, including by establishing mechanisms for—

''(i) tracking minority health and health disparity research conducted within the institutes and centers assessing the appropriateness of this research with regard to the overall goals and objectives of the plan;

''(ii) the early identification of applications and proposals for grants, contracts, and cooperative agreements supporting extramural training, research, and development, that are submitted to the institutes and centers that are within the mission of the Institute;

''(iii) providing the Institute with the written descriptions and scientific peer review results of such applications and proposals;

''(iv) enabling the institutes and centers to consult with the Director of the Institute prior to final approval of such applications and proposals; and

''(v) reporting to the Director of the Institute all such applications and proposals that are approved for funding by the institutes and centers.

''(2) CERTAIN COMPONENTS OF PLAN AND BUDGET.—With respect to health disparities research activities of the agencies of the National Institutes of Health, the Director of the Institute shall ensure that the plan and budget under paragraph (1) provide for—

''(A) basic research and applied research, including research and development with respect to products;

''(B) research that is conducted by the agencies;

''(C) research that is supported by the agencies;

''(D) proposals developed pursuant to solicitations by the agencies and for proposals developed independently of such solicitations; and

''(E) behavioral research and social sciences research, which may include cultural and linguistic research in each of the agencies.

''(3) MINORITY HEALTH DISPARITIES RESEARCH.—The plan and budget under paragraph (1) shall include a separate statement of the plan and budget for minority health disparities research.'';

(3) by amending subsection (h) to read as follows:

''(h) RESEARCH ENDOWMENTS.—

''(1) IN GENERAL.—The Director of the Institute shall carry out a program to facilitate minority health and health disparities research and other health disparities research by providing research endowments at—

''(A) centers of excellence under section 736; and

''(B) centers of excellence under section 485F.

''(2) ELIGIBILITY.—The Director of the Institute shall provide for a research endowment under paragraph (1) only if the institution involved meets the following conditions:

''(A) The institution does not have an endowment that is worth in excess of an amount equal to 50 percent of the national average of endowment funds at institutions that conduct similar biomedical research or training of health professionals.

''(B) The application of the institution under paragraph (1) regarding a research endowment has been recommended pursuant to technical and scientific peer review and has been approved by the advisory council established pursuant to subsection (j).

''(C) The institution at any time was deemed to be eligible to receive a grant under section 736 and at any time received a research endowment under paragraph (1).''; and

(4) by adding at the end the following:

''(k) FUNDING.—

''(1) FULL FUNDING BUDGET.—

''(A) IN GENERAL.—With respect to a fiscal year, the Director of the Institute shall prepare and submit directly to the President, for review and transmittal to Congress, a budget estimate for carrying out the plan for the fiscal year, after reasonable opportunity for comment (but without change) by the Secretary, the Director of the National Institutes of Health, the directors of the other institutes and centers of the National Institutes of Health, and the advisory council established pursuant to subsection (j). The budget estimate shall include an estimate of the number and type of personnel needs for the Institute.

''(B) AMOUNTS NECESSARY.—The budget estimate submitted under subparagraph (A) shall estimate the amounts necessary for the institutes and centers of the National Institutes of Health to carry out all minority health and health disparities activities determined by the Director of the Institute to be appropriate, without regard to the probability that such amounts will be appropriated.

''(2) ALTERNATE BUDGETS.—

''(A) IN GENERAL.—With respect to a fiscal year, the Director of the Institute shall prepare and submit to the Secretary and the Director of the National Institutes of Health the budget estimates described in subparagraph (B) for carrying out the plan for the fiscal year. The Secretary and such Director shall consider each of such estimates in making recommendations to the President regarding a budget for the plan for such year.

''(B) DESCRIPTION.—With respect to the fiscal year involved, the budget estimates referred to in subparagraph (A) for the plan are as follows:

''(i) The budget estimate submitted under paragraph (1).

''(ii) A budget estimate developed on the assumption that the amounts appropriated will be sufficient only for—

''(I) continuing the conduct by the institutes and centers of the National Institutes of Health of existing minority health and health disparity activities (if approved for continuation), and continuing the support of such activities by the institutes and centers in the case of projects or programs for which the institutes or centers have made a commitment of continued support; and

''(II) carrying out activities that are in addition to activities specified in subclause (I), only for which the Director determines there is the most substantial need.

''(iii) Such other budget estimates as the Director of the Institute determines to be appropriate.''.

SA 2879. Mr. CARDIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 974, between lines 9 and 10, insert the following:

SEC. 3316. HHS STUDIES AND REPORTS ON MEDICAID BENEFICIARIES AND DUAL ELIGIBLE INDIVIDUALS RECEIVING CARE IN HOME AND COMMUNITY-BASED SETTINGS.

(a) STUDY AND REPORT ON DUAL ELIGIBLES.—Not later than 180 days after the date of enactment of this Act, the Secretary shall conduct a study and submit to Congress a report that—

(1) analyzes whether dual eligible individuals (as described under subsection (c)(1)) have income levels, prescription drug requirements, and types and levels of disability that are comparable to dual eligible individuals for whom cost-sharing is eliminated under section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(D)(i)), as amended by section 3309;

(2) determines whether dual eligible individuals have adequate access to prescription medication; and

(3) provides recommendations to address any deficiencies in regard to access to prescription drugs by dual eligible individuals, including an analysis regarding elimination of cost sharing for all such individuals under the prescription drug program under part D of title XVIII of the Social Security Act.

(b) STUDY AND REPORT ON SSI LOW-INCOME MEDICAID BENEFICIARIES.—Not later than 12 months after the date of enactment of this Act, the Secretary shall conduct a study and submit to Congress a report that—

(1) determines whether benefits provided to SSI Medicaid beneficiaries (as described under subsection (c)(2)) under the supplemental security income program are sufficient to cover expenses for room and board that are incurred by such beneficiaries;

(2) analyzes the process used for determining the amount of benefits provided to SSI Medicaid beneficiaries under the supplemental security income program, including whether such amounts—

(A) adequately reflect expenses for room and board that are incurred by such beneficiaries; and

(B) are sufficient to meet the needs of beneficiaries who are disabled; and

(3) identifies methods to provide additional support for SSI Medicaid beneficiaries in covering their expenses for room and board, including benefits provided under Housing and Urban Development programs and other housing assistance programs, the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.), and other methods as determined appropriate by the Secretary.

(c) DEFINITIONS.—In this section:

(1) DUAL ELIGIBLE INDIVIDUAL.—The term ''dual eligible individual'' means an individual who is—

(A) entitled to benefits under part A of title XVIII of the Social Security Act or enrolled for benefits under part B of such title;

(B) entitled to medical assistance under a State plan under title XIX of such Act;

(C) not an institutionalized individual or couple (as defined in section 1902(q)(1)(B) of such Act (42 U.S.C. 1396a(q)(1)(B))); and

(D) receiving home and community-based services under a State Medicaid plan (or a waiver of such plan) under title XIX of the Social Security Act.

(2) SSI MEDICAID BENEFICIARY.—The term ''SSI Medicaid beneficiary'' means an individual who—

(A) is eligible for medical assistance under a State plan or waiver under title XIX of the Social Security Act and is enrolled in such plan or waiver;

(B) receives benefits under the supplemental security income program under title XVI of the Social Security Act (42 U.S.C. 1381 et seq.); and

(C) receives home and community-based services (including such services provided in an assisted living facility).

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on December 3, 2009, at 10 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on December 3, 2009.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate to conduct a hearing on December 3, 2009, at 10 a.m., in Room SD–366 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on December 3, 2009, at 9 a.m., to hold a hearing entitled ''Afghanistan: Assessing the Road Ahead.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 3, 2009, at 10 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON INDIAN AFFAIRS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet during the session of the Senate in Room 628 on December 3, 2009, at 2:15 p.m. of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on December 3, 2009, at 10 a.m., in Room SD–226 of the Dirksen Senate Office Building, to conduct an executive business meeting.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on December 3, 2009, at 2:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON NATIONAL PARKS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Subcommittee on National Parks be authorized to meet during the session of the Senate to conduct a hearing on December 3, 2009, at 2:30 p.m., in Room SD–366 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON WATER AND WILDLIFE

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Subcommittee on Water and Wildlife of the Committee on Environment and Public Works be authorized to meet during the session of the Senate on December 3, 2009, at 2 p.m. in Room 406 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGES OF THE FLOOR

Mr. BAUCUS. Mr. President, I ask unanimous consent that Stacey Sachs, a detailee in the Senate HELP Committee Majority Health Office, be granted the privileges of the floor for the duration of H.R. 3590, the Patient Protection and Affordable Care Act.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. HATCH. Mr. President, I ask unanimous consent that my health policy fellow, Dr. Janet Phoenix, have floor privileges throughout the consideration of this debate on H.R. 3590.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

EXECUTIVE SESSION

PROTOCOL AMENDING TAX CONVENTION WITH FRANCE

Mr. CASEY. Mr. President, I ask unanimous consent that the Senate proceed to executive session to consider Executive Calendar No. 1, Treaty Document No. 111–4, Protocol Amending Tax Convention with France; that the treaty be considered as having advanced through the various parliamentary stages, up to and including the presentation of the resolution of ratification; that any committee understanding, declaration, or condition be agreed to as applicable; that any statements be printed in the RECORD; further, that when the vote on the resolution of ratification is taken, the motion to reconsider be considered made and laid upon the table, and the President be immediately notified of the Senate's action.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. CASEY. Mr. President, I ask for a division vote on the resolution of ratification.

The PRESIDING OFFICER. A division vote has been requested. Senators in favor of the resolution of ratification will rise and stand until counted. Those opposed will rise and stand until counted.

On a division, two-thirds of the Senators present and voting having voted in the affirmative, the resolution of ratification is agreed to.

The resolution of ratification agreed to is as follows:

Resolved, (two-third of the Senators present concurring therein),

Section 1. Senate Advice and Consent subject to a declaration and a condition.

The senate advises and consents to the ratification of the Protocol Amending the convention between the Government of the United States of America and the Government of the French Republic for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income and Capital, signed at Paris on August 31, 1994, as Amended by the Protocol signed on December 8, 2004, signed on January 13, 2009, at Paris, together with a related Memorandum of Understanding, signed January 13, 2009 (the ''Protocol'') (Treaty Doc. 111–4), subject to the declaration of section 2 and the condition of section 3.

Section 2. Declaration.

The advice and consent of the Senate under section 1 is subject to the following declaration:

The Protocol is self-executing.

Section 3. Condition.

The advice and consent of the Senate under section 1 is subject to the following condition:

1. Not later than two years from the date on which this Protocol enters into force and prior to the first arbitration conducted pursuant to the binding arbitration mechanism provided for in this Protocol, the Secretary of Treasury shall transmit the text of the rules of procedure applicable to arbitration panels, including conflict of interest rules to be applied to members of the arbitration panel, to the committees on Finance and Foreign Relations of the Senate and the Joint Committee on Taxation.

2. Sixty days after a determination has been reached by an arbitration panel in the tenth arbitration proceeding conducted pursuant to this Protocol, the 2006 Protocol Amending the Convention between the United States of America and the Federal Republic of Germany for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income and Capital and to Certain Other Taxes (the ''2006 German Protocol'') (Treaty Doc. 109–20), the Convention between the Government of the United States of America and the Government of the Kingdom of Belgium for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income, and accompanying protocol (the ''Belgium Convention'') (Treaty Doc. 110–3), or the Protocol Amending the Convention between the United States of America and Canada with Respect to Taxes on Income and on Capital (the ''2007 Canada Protocol'') (Treaty Doc. 110–15), the Secretary of Treasury shall prepare and submit a detailed report to the Joint Committee on Taxation and the Committee on Finance of the Senate, subject to law relating to taxpayer confidentiality, regarding the operation and application of the arbitration mechanism contained in the aforementioned treaties. The report shall include the following information:

I. The aggregate number, for each treaty, of cases pending on the respective dates of entry into force of this Protocol, the 2006 German Protocol, the Belgium Convention, and the 2007 Canada Protocol, along with the following additional information regarding these cases:

a. The number of such cases by treaty article(s) at issue;

b. The number of such cases that have been resolved by the competent authorities through a mutual agreement as of the date of the report; and

c. The number of such cases for which arbitration proceedings have commenced as of the date of the report.

II. A list of every case presented to the competent authorities after the entry into force of this Protocol, the 2006 German Protocol, the Belgium Convention, and the 2007 Canada Protocol, with the following information regarding each case:

a. The commencement date of the case for purposes of determining when arbitration is available;

b. Whether the adjustment triggering the case, if any, was made by the United States or the relevant treaty partner;

c. Which treaty the case relates to;

d. The treaty article(s) at issue in the case;

e. The date the case was resolved by the competent authorities through a mutual agreement, if so resolved;

f. The date on which an arbitration proceeding commenced, if an arbitration proceeding commenced; and

g. The date on which a determination was reached by the arbitration panel, if a determination was reached, and an indication as to whether the panel found in favor of the United States or the relevant treaty partner.

III. With respect to each dispute submitted to arbitration and for which a determination was reached by the arbitration panel pursuant to this Protocol, the 2006 German Protocol, the Belgium Convention, and the 2007 Canada Protocol, the following information shall be included:

a. In the case of a dispute submitted under this Protocol, an indication as to whether the presenter of the case to the competent authority of a Contracting State submitted a Position Paper for consideration by the arbitration panel;

b. An indication as to whether the determination of the arbitration panel was accepted by each concerned person;

c. The amount of income, expense, or taxation at issue in the case as determined by reference to the filings that were sufficient to set the commencement date of the case for purposes of determining when arbitration is available; and

d. The proposed resolutions (income, expense, or taxation) submitted by each competent authority to the arbitration panel.

3. The Secretary of Treasury shall, in addition, prepare and submit the detailed report described in paragraph (2) on March 1 of the year following the year in which the first report is submitted to the Joint Committee on Taxation and the Committee on Finance of the Senate, and on an annual basis thereafter for a period of five years. In each such report, disputes that were resolved, either by a mutual agreement between the relevant competent authorities or by a determination of an arbitration panel, and noted as such in prior reports may be omitted.

4. The reporting requirements referred to in paragraphs (2) and (3) supersede the reporting requirements contained in paragraphs (2) and (3) of Section 3 of the 2 resolution of advice and consent to the 2007 Canada Protocol, approved by the Senate on September 23, 2008.

EXECUTIVE CALENDAR

Mr. CASEY. Mr. President, I ask unanimous consent that the Senate consider en bloc Executive Calendar Nos. 550, 555, 559, 562, 565 to and including 577, and all nominations on the Secretary's desk in the Air Force, Army, and Navy; that the nominations be confirmed en bloc, the motions to reconsider be laid upon the table en bloc; that no further motions be in order; that any statements relating to the nominations be printed in the RECORD; that the President be immediately notified of the Senate's action, and the Senate resume legislative session.

The PRESIDING OFFICER. Without objection, it is so ordered.

The nominations considered and confirmed en bloc are as follows:

DEPARTMENT OF LABOR

David Morris Michaels, of Maryland, to be an Assistant Secretary of Labor.

EXECUTIVE OFFICE OF THE PRESIDENT

Victoria Angelica Espinel, of the District of Columbia, to be Intellectual Property Enforcement Coordinator, Executive Office of the President.

UNITED STATES POSTAL SERVICE

Alan C. Kessler, of Pennsylvania, to be a Governor of the United States Postal Service for a term expiring December 8, 2015.

SELECTIVE SERVICE SYSTEM

Lawrence G. Romo, of Texas, to be Director of the Selective Service.

IN THE AIR FORCE

The following named officer for appointment in the United States Air Force to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Maj. Gen. Kurt A. Cichowski

The following named officer for appointment in the United States Air Force to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Maj. Gen. Janet C. Wolfenbarger

The following Air National Guard of the United States officer for appointment in the Reserve of the Air Force to the grade indicated under title 10, U.S.C., sections 12203 and 12212:

To be brigadier general

Col. Frank J. Sullivan

IN THE ARMY

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Maj. Gen. Guy C. Swan, III

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Brig. Gen. William N. Phillips

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Maj. Gen. Richard P. Formica

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Maj. Gen. Michael L. Oates

The following named officer for appointment in the Reserve of the Army to the grade indicated under title 10, U.S.C., section 12203:

To be major general

Brig. Gen. Charles J. Barr

IN THE NAVY

The following named officer for appointment in the United States Navy to the grade indicated under title 10, U.S.C., section 624:

To be rear admiral (lower half)

Capt. Sean R. Filipowski

The following named officer for appointment in the United States Navy to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be vice admiral

Rear Adm. John T. Blake

The following named officer for appointment in the United States Navy to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be vice admiral

Vice Adm. Bernard J. McCullough, III

The following named officer for appointment in the United States Navy to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be vice admiral

Rear Adm. Michael A. LeFever

The following named officer for appointment in the United States Navy to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be vice admiral

Rear Adm. William R. Burke

NOMINATIONS PLACED ON THE SECRETARY'S DESK

IN THE AIR FORCE

PN982 AIR FORCE nominations (34) beginning JEFFREY K. ATKISSON, and ending ROGER L. WILLIS JR., which nominations were received by the Senate and appeared in the Congressional Record of September 21, 2009.

PN983 AIR FORCE nominations (1201) beginning CHRISTOPHER C. ABATE, and ending CHRISTOPHER J. ZUHLKE, which nominations were received by the Senate and appeared in the Congressional Record of September 21, 2009.

PN1190 AIR FORCE nomination of Elisha T. Powell IV, which was received by the Senate and appeared in the Congressional Record of November 17, 2009.

IN THE ARMY

PN1113 ARMY nomination of James C. Lewis, which was received by the Senate and appeared in the Congressional Record of October 22, 2009.

PN1122 ARMY nominations (4) beginning ANULI L. ANYACHEBELU, and ending JOHN M. STANG, which nominations were received by the Senate and appeared in the Congressional Record of October 28, 2009.

PN1123 ARMY nominations (7) beginning ANTHONY C. BOSTICK, and ending JOSEPH G. WILLIAMSON, which nominations were received by the Senate and appeared in the Congressional Record of October 28, 2009.

PN1124 ARMY nominations (21) beginning RISA D. BATOR, and ending THOMAS R. YARBER, which nominations were received by the Senate and appeared in the Congressional Record of October 28, 2009.

PN1125 ARMY nominations (37) beginning JAMES R. ANDREWS, and ending SHANDA M. ZUGNER, which nominations were received by the Senate and appeared in the Congressional Record of October 28, 2009.

PN1147 ARMY nomination of Edwin S. Fuller, which was received by the Senate and appeared in the Congressional Record of November 4, 2009.

PN1148 ARMY nomination of Robert J. Schultz, which was received by the Senate and appeared in the Congressional Record of November 4, 2009.

PN1149 ARMY nominations (2) beginning CLEMENT D. KETCHUM, and ending JOHN LOPEZ, which nominations were received by the Senate and appeared in the Congressional Record of November 4, 2009.

PN1150 ARMY nominations (4) beginning CAREY L. MITCHELL, and ending MELISSA F. TUCKER, which nominations were received by the Senate and appeared in the Congressional Record of November 4, 2009.

PN1151 ARMY nominations (10) beginning CRAIG R. BOTTONI, and ending AKASH S. TAGGARSE, which nominations were received by the Senate and appeared in the Congressional Record of November 4, 2009.

PN1169 ARMY nomination of Leon L. Robert, which was received by the Senate and appeared in the Congressional Record of November 16, 2009.

PN1170 ARMY nomination of Michael C. Metcalf, which was received by the Senate and appeared in the Congressional Record of November 16, 2009.

PN1171 ARMY nominations (2) beginning TODD E. FARMER, and ending STEVEN R. WATT, which nominations were received by the Senate and appeared in the Congressional Record of November 16, 2009.

PN1172 ARMY nominations (12) beginning MARK D. CROWLEY, and ending MICHAEL

J. STEVENSON, which nominations were received by the Senate and appeared in the Congressional Record of November 16, 2009.

PN1173 ARMY nominations (141) beginning NATHANAEL L. ALLEN, and ending X001320, which nominations were received by the Senate and appeared in the Congressional Record of November 16, 2009.

PN1174 ARMY nominations (155) beginning SCOTT C. ARMSTRONG, and ending D004309, which nominations were received by the Senate and appeared in the Congressional Record of November 16, 2009.

PN1175 ARMY nominations (212) beginning MICHAEL W. ANASTASIA, and ending D003756, which nominations were received by the Senate and appeared in the Congressional Record of November 16, 2009.

PN1191 ARMY nomination of Scott E. McNeil, which was received by the Senate and appeared in the Congressional Record of November 17, 2009.

PN1192 ARMY nomination of Scott E. Zipprich, which was received by the Senate and appeared in the Congressional Record of November 17, 2009.

PN1193 ARMY nomination of Mary B. McQuary, which was received by the Senate and appeared in the Congressional Record of November 17, 2009.

PN1194 ARMY nominations (3) beginning MARVIN R. MANIBUSAN, and ending FRANCISCO J. NEUMAN, which nominations were received by the Senate and appeared in the Congressional Record of November 17, 2009.

PN1195 ARMY nominations (4) beginning PATRICK S. CALLENDER, and ending STEVEN L. SHUGART, which nominations were received by the Senate and appeared in the Congressional Record of November 17, 2009.

PN1196 ARMY nominations (14) beginning MICHAEL A. BENNETT, and ending KEVIN M. WALKER, which nominations were received by the Senate and appeared in the Congressional Record of November 17, 2009.

IN THE NAVY

PN1114 NAVY nominations (2) beginning TIMOTHY M. SHERRY, and ending ROBERT N. MILLS, which nominations were received by the Senate and appeared in the Congressional Record of October 22, 2009.

PN1176 NAVY nomination of Matthew P. Luff, which was received by the Senate and appeared in the Congressional Record of November 16, 2009.

PN1177 NAVY nomination of Everett F. Magann, which was received by the Senate and appeared in the Congressional Record of November 16, 2009.

PN1178 NAVY nomination of William V. Dolan, which was received by the Senate and appeared in the Congressional Record of November 16, 2009.

PN1179 NAVY nominations (48) beginning BRIAN D. BARTH, and ending STACY M. WUTHIER, which nominations were received by the Senate and appeared in the Congressional Record of November 16, 2009.

NOMINATION OF VICTORIA ESPINEL

Mr. LEAHY. Mr. President, I am pleased that the Senate today confirmed Victoria Espinel as the Nation's first intellectual property enforcement coordinator. This position was created by legislation that I introduced last year and is vital to protect the intellectual property interests of United States innovators and companies. Intellectual property rights promote innovation and creativity, and the protection of those rights is critical during this time of economic uncertainty.

Ms. Espinel is extremely well qualified to serve as the President's intellectual property enforcement coordinator. She has an extensive background in intellectual property issues, both foreign and domestic, and has experience in government and in the private sector. Ms. Espinel served in the Bush administration as the Assistant United States Trade Representative for Intellectual Property and Innovation. This is a nomination that deserves bipartisan support. American innovation and our intellectual property protection should not be a partisan issue.

The legislation by which we created this position took a comprehensive approach to intellectual property protection by providing Federal, State, and local law enforcement with the tools and resources they need to combat intellectual property theft. The legislation created an interagency advisory committee to develop a more efficient and cohesive approach to protecting American intellectual property. I am confident that Ms. Espinel will work well with that committee.

I look forward to working with Ms. Espinel to improve the efficiency and effectiveness of our intellectual property enforcement efforts. I know her family, and was delighted to chair her confirmation hearing. I congratulate her on her Senate confirmation.

LEGISLATIVE SESSION

The PRESIDING OFFICER. Under the previous order, the Senate will resume legislative session.

NATIONAL MINERS DAY

Mr. CASEY. Mr. President, I ask unanimous consent that the Judiciary Committee be discharged from further consideration of S. Res. 337 and that the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the resolution by title.

The bill clerk read as follows:

A resolution (S. Res. 337) designating December 6, 2009, as ''National Miners Day.''

There being no objection, the Senate proceeded to consider the resolution.

Mr. CASEY. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and that any statements related to the resolution be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 337) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 337

Whereas the foundations of civilization are constructed from, advanced by, and sustained with, the materials procured with the sweat and blood of miners;

Whereas the miners of the United States have labored long and hard over our Nation's existence to make it the economically strong, militarily secure Nation that it is today;

Whereas miners and their families have achieved, provided, and sacrificed so much for the betterment of their fellow Americans;

Whereas miners have struggled, in their lives and in their work, to obtain health and safety protections;

Whereas the terrible mining tragedy at Monongah, West Virginia, that occurred on December 6, 1907, is recognized for causing the greatest loss of lives in American industrial history, and this tragedy helped to launch the national effort to secure the safety and health of our miners that continues to this day; and

Whereas miners still today risk life and limb in their labors: Now, therefore, be it

Resolved, That the Senate—

(1) designates December 6, 2009, as ''National Miners Day'', in appreciation, honor, and remembrance of the accomplishments and sacrifices of the miners of the Nation; and

(2) encourages the people of the United States to participate in local and national activities celebrating and honoring the contributions of miners.

PERMITTING COLLECTIONS FOR CHARITABLE PURPOSES

Mr. CASEY. Mr. President, I ask unanimous consent that the Senate now proceed to the consideration of S. Res. 369, which was submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The bill clerk read as follows:

A resolution (S. Res. 369) to permit the collection of clothing, toys, food, and housewares during the holiday season for charitable purposes in Senate buildings.

There being no objection, the Senate proceeded to consider the resolution.

Mr. CASEY. I ask unanimous consent that the resolution be agreed to and the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 369) was agreed to, as follows:

S. RES. 369

Resolved,

SECTION 1. COLLECTION OF CLOTHING, TOYS, FOOD, AND HOUSEWARES DURING THE HOLIDAY SEASON FOR CHARITABLE PURPOSES IN SENATE BUILDINGS.

(a) IN GENERAL.—Notwithstanding any other provision of the rules or regulations of the Senate—

(1) a Senator, officer, or employee of the Senate may collect from another Senator, officer, or employee of the Senate within Senate buildings nonmonetary donations of clothing, toys, food, and housewares for charitable purposes related to serving those in need or members of the Armed Services and their families during the holiday season, if such purposes do not otherwise violate any rule or regulation of the Senate or of Federal law; and

(2) a Senator, officer, or employee of the Senate may work with a nonprofit organization with respect to the delivery of donations described in paragraph (1).

(b) EXPIRATION.—The authority provided by this resolution shall expire at the end of the 1st session of the 111th Congress.

ORDERS FOR FRIDAY, DECEMBER 4, 2009

Mr. CASEY. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m. tomorrow, Friday, December 4; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation, as provided for under the previous order.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. CASEY. Mr. President, we currently have one amendment and one motion to commit pending to the bill. Senators should expect rollcall votes throughout the day tomorrow.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. CASEY. If there is no further business to come before the Senate, I ask unanimous consent it adjourn under the previous order.

There being no objection, the Senate, at 8:32 p.m., adjourned until Friday, December 4, 2009, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF ENERGY

DONALD L. COOK, OF WASHINGTON, TO BE DEPUTY ADMINISTRATOR FOR DEFENSE PROGRAMS, NATIONAL NUCLEAR SECURITY ADMINISTRATION, VICE ROBERT L. SMOLEN, RESIGNED.

DEPARTMENT OF DEFENSE

MALCOLM ROSS O'NEILL, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF THE ARMY, VICE CLAUDE M. BOLTON, JR.

JACKALYNE PFANNENSTIEL, OF CALIFORNIA, TO BE AN ASSISTANT SECRETARY OF THE NAVY, VICE BUDDIE J. PENN.

DOUGLAS B. WILSON, OF ARIZONA, TO BE AN ASSISTANT SECRETARY OF DEFENSE, VICE DORRANCE SMITH.

DEPARTMENT OF STATE

BROOKE D. ANDERSON, OF CALIFORNIA, TO BE ALTERNATE REPRESENTATIVE OF THE UNITED STATES OF AMERICA FOR SPECIAL POLITICAL AFFAIRS IN THE UNITED NATIONS, WITH THE RANK OF AMBASSADOR.

BROOKE D. ANDERSON, OF CALIFORNIA, TO BE AN ALTERNATE REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SESSIONS OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS, DURING HER TENURE OF SERVICE AS ALTERNATE REPRESENTATIVE OF THE UNITED STATES OF AMERICA FOR SPECIAL POLITICAL AFFAIRS IN THE UNITED NATIONS.

ROSEMARY ANNE DICARLO, OF THE DISTRICT OF COLUMBIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER—COUNSELOR, TO BE THE DEPUTY REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE UNITED NATIONS, WITH THE RANK AND STATUS OF AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY, AND THE DEPUTY REPRESENTATIVE OF THE UNITED STATES OF AMERICA IN THE SECURITY COUNCIL OF THE UNITED NATIONS.

ROSEMARY ANNE DICARLO, OF THE DISTRICT OF COLUMBIA, A CAREER MEMBER OF THE SENIOR FOREIGN SERVICE, CLASS OF MINISTER—COUNSELOR, TO BE REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE SESSIONS OF THE GENERAL ASSEMBLY OF THE UNITED NATIONS, DURING HER TENURE OF SERVICE AS DEPUTY REPRESENTATIVE OF THE UNITED STATES OF AMERICA TO THE UNITED NATIONS.

THE JUDICIARY

NANCY D. FREUDENTHAL, OF WYOMING, TO BE UNITED STATES DISTRICT JUDGE FOR THE DISTRICT OF WYOMING, VICE CLARENCE A. BRIMMER, JR., RETIRED.

DENZIL PRICE MARSHALL, JR., OF ARKANSAS, TO BE UNITED STATES DISTRICT JUDGE FOR THE EASTERN DISTRICT OF ARKANSAS, VICE WILLIAM ROY WILSON, JR., RETIRED.

BENITA Y. PEARSON, OF OHIO, TO BE UNITED STATES DISTRICT JUDGE FOR THE NORTHERN DISTRICT OF OHIO, VICE PETER C. ECONOMUS, RETIRED.

CONFIRMATIONS

Executive nominations confirmed by the Senate, Thursday, December 3, 2009:

DEPARTMENT OF LABOR

DAVID MORRIS MICHAELS, OF MARYLAND, TO BE AN ASSISTANT SECRETARY OF LABOR.

UNITED STATES POSTAL SERVICE

ALAN C. KESSLER, OF PENNSYLVANIA, TO BE A GOVERNOR OF THE UNITED STATES POSTAL SERVICE FOR A TERM EXPIRING DECEMBER 8, 2015.

SELECTIVE SERVICE SYSTEM

LAWRENCE G. ROMO, OF TEXAS, TO BE DIRECTOR OF THE SELECTIVE SERVICE .

THE ABOVE NOMINATIONS WERE APPROVED SUBJECT TO THE NOMINEES' COMMITMENT TO RESPOND TO REQUESTS TO APPEAR AND TESTIFY BEFORE ANY DULY CONSTITUTED COMMITTEE OF THE SENATE.

EXECUTIVE OFFICE OF THE PRESIDENT

VICTORIA ANGELICA ESPINEL, OF THE DISTRICT OF COLUMBIA, TO BE INTELLECTUAL PROPERTY ENFORCEMENT COORDINATOR, EXECUTIVE OFFICE OF THE PRESIDENT.

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. KURT A. CICHOWSKI

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. JANET C. WOLFENBARGER

THE FOLLOWING AIR NATIONAL GUARD OF THE UNITED STATES OFFICER FOR APPOINTMENT IN THE RESERVE OF THE AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTIONS 12203 AND 12212:

To be brigadier general

COL. FRANK J. SULLIVAN

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. GUY C. SWAN III

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

BRIG. GEN. WILLIAM N. PHILLIPS

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. RICHARD P. FORMICA

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. MICHAEL L. OATES

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE RESERVE OF THE ARMY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be major general

BRIG. GEN. CHARLES J. BARR

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

To be rear admiral (lower half)

CAPT. SEAN R. FILIPOWSKI

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be vice admiral

REAR ADM. JOHN T. BLAKE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be vice admiral

VICE ADM. BERNARD J. MCCULLOUGH III

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be vice admiral

REAR ADM. MICHAEL A. LEFEVER

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be vice admiral

REAR ADM. WILLIAM R. BURKE

IN THE AIR FORCE

AIR FORCE NOMINATIONS BEGINNING WITH JEFFREY K. ATKISSON AND ENDING WITH ROGER L. WILLIS, JR., WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON SEPTEMBER 21, 2009.

AIR FORCE NOMINATIONS BEGINNING WITH CHRISTOPHER C. ABATE AND ENDING WITH CHRISTOPHER J. ZUHLKE, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON SEPTEMBER 21, 2009.

AIR FORCE NOMINATION OF ELISHA T. POWELL IV, TO BE COLONEL.

IN THE ARMY

ARMY NOMINATION OF JAMES C. LEWIS, TO BE MAJOR.

ARMY NOMINATIONS BEGINNING WITH ANULI L. ANYACHEBELU AND ENDING WITH JOHN M. STANG, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON OCTOBER 28, 2009.

ARMY NOMINATIONS BEGINNING WITH ANTHONY C. BOSTICK AND ENDING WITH JOSEPH G. WILLIAMSON, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON OCTOBER 28, 2009.

ARMY NOMINATIONS BEGINNING WITH RISA D. BATOR AND ENDING WITH THOMAS R. YARBER, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON OCTOBER 28, 2009.

ARMY NOMINATIONS BEGINNING WITH JAMES R. ANDREWS AND ENDING WITH SHANDA M. ZUGNER, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON OCTOBER 28, 2009.

ARMY NOMINATION OF EDWIN S. FULLER, TO BE MAJOR.

ARMY NOMINATION OF ROBERT J. SCHULTZ, TO BE LIEUTENANT COLONEL.

ARMY NOMINATIONS BEGINNING WITH CLEMENT D. KETCHUM AND ENDING WITH JOHN LOPEZ, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON NOVEMBER 4, 2009.

ARMY NOMINATIONS BEGINNING WITH CAREY L. MITCHELL AND ENDING WITH MELISSA F. TUCKER, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON NOVEMBER 4, 2009.

ARMY NOMINATIONS BEGINNING WITH CRAIG R. BOTTONI AND ENDING WITH AKASH S. TAGGARSE, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON NOVEMBER 4, 2009.

ARMY NOMINATION OF LEON L. ROBERT, TO BE COLONEL.

ARMY NOMINATION OF MICHAEL C. METCALF, TO BE COLONEL.

ARMY NOMINATIONS BEGINNING WITH TODD E. FARMER AND ENDING WITH STEVEN R. WATT, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON NOVEMBER 16, 2009.

ARMY NOMINATIONS BEGINNING WITH MARK D. CROWLEY AND ENDING WITH MICHAEL J. STEVENSON, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON NOVEMBER 16, 2009.

ARMY NOMINATIONS BEGINNING WITH NATHANAEL L. ALLEN AND ENDING WITH X001320, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON NOVEMBER 16, 2009.

ARMY NOMINATIONS BEGINNING WITH SCOTT C. ARMSTRONG AND ENDING WITH D004309, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON NOVEMBER 16, 2009.

ARMY NOMINATIONS BEGINNING WITH MICHAEL W. ANASTASIA AND ENDING WITH D003756, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON NOVEMBER 16, 2009.

ARMY NOMINATION OF SCOTT E. MCNEIL, TO BE COLONEL.

ARMY NOMINATION OF SCOTT E. ZIPPRICH, TO BE COLONEL.

ARMY NOMINATION OF MARY B. MCQUARY, TO BE COLONEL.

ARMY NOMINATIONS BEGINNING WITH MARVIN R. MANIBUSAN AND ENDING WITH FRANCISCO J. NEUMAN,

WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON NOVEMBER 17, 2009.

ARMY NOMINATIONS BEGINNING WITH PATRICK S. CALLENDER AND ENDING WITH STEVEN L. SHUGART, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON NOVEMBER 17, 2009.

ARMY NOMINATIONS BEGINNING WITH MICHAEL A. BENNETT AND ENDING WITH KEVIN M. WALKER, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON NOVEMBER 17, 2009.

IN THE NAVY

NAVY NOMINATIONS BEGINNING WITH TIMOTHY M. SHERRY AND ENDING WITH ROBERT N. MILLS, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON OCTOBER 22, 2009.

NAVY NOMINATION OF MATTHEW P. LUFF, TO BE LIEUTENANT COMMANDER.

NAVY NOMINATION OF EVERETT F. MAGANN, TO BE CAPTAIN.

NAVY NOMINATION OF WILLIAM V. DOLAN, TO BE CAPTAIN.

NAVY NOMINATIONS BEGINNING WITH BRIAN D. BARTH AND ENDING WITH STACY M. WUTHIER, WHICH NOMINATIONS WERE RECEIVED BY THE SENATE AND APPEARED IN THE CONGRESSIONAL RECORD ON NOVEMBER 16, 2009.